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INSTITUTE OF MEDICINE STUDY ON NURSING HOME REGULATION

JOINT HEARING

ORIGINAL

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

AND THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

AND THE

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

MARCH 25, 1986

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INSTITUTE OF MEDICINE STUDY ON NURSING HOME REGULATION

TUESDAY, MARCH 25, 1986

HOUSE OF REPRESENTATIVES, COMMITTEE ON ENERGY AND COMMERCE, SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS, AND SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT, WITH SELECT COMMITTEE ON AGING, SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE,

Washington, DC.

The subcommittees met, pursuant to call, at 10 a.m., in room 2123, Rayburn House Office Building, Hon. John D. Dingell, chairman, of the Subcommittee on Oversight and Investigations, presiding.

Mr. DINGELL. The three subcommittees will come to order.

Today, we meet to conduct a joint hearing on nursing home regulation and the report entitled "The Improving of the Quality of Nursing Homes," by the Institute of Medicine.

We are particularly delighted to have with us our distinguished friend and colleague, the chairman of the Rules Committee, and also the chairman of the Subcommittee on Long-Term Care of the Select Committee on Aging; and our dear friend, Mr. Waxman, chairman of the Health Subcommittee of the Committee on Energy and Commerce.

The Chair recognizes for opening statements first the distinguished chairman of the Rules Committee and then my good friend from California, Mr. Waxman.

[The opening statement of Mr. Dingell follows:]

OPENING STATEMENT OF HON. JOHN D. DINGELL

Today may set the scene for the enactment of important changes in long-term care for the elderly in America. The report of the Institute of Medicine, which will be presented to our Committees today, signals the end of an era. Until now, law and rules sought only to increase and improve the resources for nursing home care.

The report by the Institute of Medicine calls for the effective use of those resources and for government intervention to promote the safety, and effective care for all nursing home residents and to protect their basic rights. The system should look directly at what is happening to those residents and require everyone to attend to them. If that concept is adopted, the Institute of Medicine concludes we can refocus the whole nursing home industry on the residents. A long overdue reform!

For the first ten years of Medicare and Medicaid, we sought to eliminate fire traps and upgrade staffing. The massive flow of money converted the unsafe and unregulated homes of the 1960s into a firmly established nursing home industry. But we did little to improve the care of residents. By 1974, a small group of visionaries, including Dr. Katz who will testify today, convinced the Department of Health and Human Services that if nursing home regulation did not look at the residents themselves, compliance with the rules would not assure good care for residents.

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For the last ten years there has been slow but steady progress in state government, in the Health Care Financing Administration, and in parts of the nursing home industry toward adopting a resident oriented system for protecting nursing home residents. In 1980, the Health Care Financing Administration signed a consent order in Federal court agreeing to implement an enforcement system based on patient or resident assessment.

In 1981 this Committee had to step in to prevent a radical reversal of progress. The White House, as part of so-called regulatory reform, proposed to deregulate nursing homes. Congress was forced to enact a moratorium on deregulation. Following the moratorium, the Health Care Financing Administration, responding to both consumers and the industry, agreed to seek advice from the Institute of Medicine and voluntarily to suspend plans to deregulate. We now have this advice.

In this hearing we expect to learn how nursing home regulation can be refocused on what is happening to residents. The Committees want to learn how such changes will improve patient care and the quality of life in nursing homes. We want to hear about other reforms that will improve the lot of nursing home residents. How can the Federal government protect nursing home residents from the abuses and dangers that still exist?

We are very grateful to the Institute of Medicine for conducting this study. Without this effort to build a strong consensus among the industry, residents' advocacy groups, state regulators, and independent experts, no one would be optimistic about nursing home reform. But thanks to the Institute of Medicine, the goal that has eluded us for over ten years seems attainable.

Mr. PEPPER. Thank you, Mr. Chairman.

I am particularly honored and pleased to be associated here today with two of my illustrious and outstanding colleagues in the whole field of health care, Hon. John Dingell and Hon. Henry Waxman.

It is a privilege to work with them to try to provide better medical care for the people of our country, especially for the elderly people, because we all recognize that they are upon the last part of a long journey of life. We want our programs for their care to do everything that medical science can do to extend their lifespan, to increase and improve their health care, and to provide for their happiness. That is the last part of their long journey.

Today, we are going to hear from the illustrious American institution, founded in 1862 by Abraham Lincoln, the National Academy of Sciences, one of the most respected scientific organizations in our land.

They are dealing with the critical subject of the protection that people get who have been confined to nursing homes. We've seen some indication that there is a disposition on the part of the administration to diminish the quality of the regulations, and, therefore, the quality of the care received by those who are in the Nation's nursing homes, constituting about 1.5 million of our people, most of them elderly people.

As a matter of fact, the average age, I am told, of the Nation's folks in nursing homes is 83. They are alone, as I indicated by the fact that 9 out of 10 of them have no spouse.

In addition to that, they are the victims of various kinds of diseases—arthritis, heart disease, sometimes early or advanced stages of Alzheimer's disease, and many others.

They are confined in those homes, and too often denied even the rudimentary freedoms that we think people should be entitled to enjoy.

For example, they ordinarily don't decide when they can go to bed or speak, and they generally are not given the right to complain when they have been abused.

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Their meager funds are in jeopardy, and it has been revealed that the few private possessions of these people are often depleted by members of the staff. Many of them are abused by neglect or by action.

For example, we had a case of a person confined in a nursing home in one of our States, who after being in the nursing home for a while, developed bedsores, and those sores became gangrenous, and the patient died. All in the world he needed was more turning over in the bed to prevent those bedsores, and they tell me now, through our Space Program, our Aviation Program, that there are kinds of sheets that could be put on the bed to prevent the bedsores from developing in the case of persons confined for a long period of time.

We had another case in the District of Columbia, where an elderly woman was put in almost boiling water in a bathtub and severely burned, but instead of being medically treated and the fact being revealed, they wrapped her up in sheets to conceal the kind of injuries she received.

She died a little while later.

So what we are talking about is trying to assure that the people that are confined in nursing homes will receive the kind of care that they are entitled to receive.

The U.S. Government pays about 75 percent of the cost of the regulatory Inspection Program.

The inspection program is primarily carried out by the States, but apparently, the Federal Government has little to do with either setting the standards of checking up on the quality of inspection, and there is evidence that sometimes the State inspectors do what sheriffs are reputed to have done in prohibition days, and that is send word ahead that they were coming.

Too often, it is known in advance that the inspector is coming. I, one time, suggested to the Governor of Florida that we put more senior citizens on the inspecting force. They would be conscientious about it, and concerned because so many of their people would be affected.

Our subcommittee has conducted hearings, and so have my distinguished colleagues, to disclose these abuses in the past.

So far, the Federal Government has been able to do, and under present regulations, can do relatively little, except close down a nursing home.

I believe my information is that they close down maybe 32 out of 15,000 each year, that is all, but if you close down a nursing home, you may have vindicated the inspector's recommendation, but what about the care that they are providing, so that seems to be a rather unhappy option for the Federal Government.

Now, then, we requested that the National Academy of Sciences make a thorough investigation of this matter, and it has now done so. We are here today to hear representatives of the National Academy of Sciences tell us about their findings and recommendations.

I have introduced a package of bills intended to implement the recommendations of the National Academy of Sciences, and I am sure my colleagues and I will be joining together in trying to devel-

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op a program when we have heard the recommendations of the National Academy.

I want to commend in the warmest way the excellence of the study made by the National Academy of Sciences, this other instance of their great contribution, and we are very, very pleased to have them here today to tell us of their findings.

Thank you very much, Mr. Chairman.

[Mr. Pepper's prepared statement follows:]

STATEMENT OF HON. CLAUDE PEPPER

Ladies and gentlemen, members of the subcommittee: It is a pleasure to join Hon. John Dingell, Chairman of the House Energy and Commerce Committee, and Hon. Henry Waxman, Chairman of the Energy and Commerce Subcommittee on Health and the Environment in convening today's hearing on nursing home reform.

In 1982, the Reagan administration proposed to significantly weaken the Federal Government's role in regulating nursing homes. My distinguished colleagues, Mr. Dingell and Mr. Waxman, joined me in leading congressional opposition to this deregulatory proposal and were successful in mandating a 1-year moratorium on all changes to nursing home regulations pending an independent study by the National Academy of Sciences. The Academy completed its national study several weeks ago. It findings and recommendations are the subject of today's hearing.

Today's hearing is significant. It recognizes the need to adequately protect and care for our Nation's most vulnerable population—the 1.5 million Americans confined in our country's 15,000 nursing homes.

Nursing home residents need care and they need protection. Their following characterists bear witness to that fact:

They are elderly.—The average age of a nursing home resident is 83.

They are alone.—Nine out of 10 have no living spouse.

They are ill.—Half have Alzheimer's disease; half have heart disease, hypertension, and/or arthritis; one-third have impaired vision or hearing; most have multiple chronic impairments.

They are very dependent.—Nine out of 10 require assistance in bathing; 4 out of 10 require assistance in eating.

They stay for a long time—Seven out 10 stay longer than a year; 2 out of 10 stay longer than 5 years; only 1 in 5 will return home.

A September, 1985 hearing by the Subcommittee on Health and Long-Term Care revealed that the violation of one or more basic human rights is an everyday fact of life for most nursing home residents. We found that:

75 percent may be denied the basic right to complain and seek redress of grievances without fear of retribution;

70 percent may be denied the right to make basic choices such as when and what to eat and when to go to sleep and awake;

45 percent may be denied the right to maintain personal possessions; many are the victims of frequent thefts;

35 percent may be denied adequate and appropriate medical and nursing care;

20 percent may be denied a safe and clean living environment;

15 percent may be the victims of physical or sexual abuse.

Abuse and neglect, sometimes resulting in death, come to light in testimony before our subcommittee:

A blind American veteran entered a Texas nursing home after he had been hospitalized. He died 35 days later of gangriene infested bedsores caused by neglect by the nursing home;

An elderly Washington, DC woman was placed by a nurse's aide in a tub of scalding bath water. Instead of calling a doctor, they wrapped the women in bed sheets to hide her wounds. She died several day later.

Although the Federal Government is paying nearly $12 billion for nursing home care, little is done to ensure the protection of those residing in such institutions:

Only 1 percent of all Federal nursing home standards measure the actual provision of quality care. Most measure only a facility's capacity to provide them;

Federal standards allow many nursing homes to leave the sole supervision of frail elderly residents during the nights to untrained nurses' aides;

Federal standards do not prescribe the enforcement of a patient's bill of rights as a necessary condition of participation;

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The Federal Government is limited in its ability to take action against poor quality nursing homes. Its only option is to close these facilities, and because of bed shortages—this sanction is seldom enforced. In 1984, only 32 of the 15,000 nursing homes were closed, and most of these were back in business weeks later;

Federal nursing home standards allow for only very limited participation by consumer and community representatives.

The National Academy of Sciences study provides an independent validation of numerous congressional hearings and investigations over the past two decades. The study sends a clear and unified message from consumers, providers, and regulators that the current system is grossly inadequate and that it must be significantly strengthened rather than diluted.

The Congress has delayed action on nursing home reform pending the findings of the important study we will hear about today and which I believe offers the direction for meaningful reform.

I introduced last week legislation, H.R. 4485, the Nursing Home Resident Protection Act of 1986, which would carry out and expand upon the recommendations of this distinguished panel. I hope we can work together in bringing about a system of nursing home care which we can all be proud of.

I look forward to today's testimony. I congratulate National Academy for its fine work.

Thank you.

Mr. DINGELL. The Chair thanks the distinguished gentleman from Florida, and the Chair recognizes now the very capable chairman of the Health Subcommittee, my friend, Mr. Waxman.

Mr. WAXMAN. Thank you very much, Mr. Chairman.

Almost 4 years ago, the Reagan administration proposed to change the Nation's standards for nursing home care. In the name of "deregulation," it tried to reduce and replace many of the basic safeguards that protect the 1½ million people who live in nursing facilities and who depend on them for care.

The response to the administration's proposals was strong, swift, and sure. And the consensus was clear: The changes went too far; the changes came too soon; and the changes hurt too much.

Through the efforts of the three subcommittees represented here today, this consensus became a legislative mandate to stop the administration's proposals and to study the issue carefully and thoroughly before any deregulation went forward. The result of this mandate was an administration-sponsored review to be undertaken by the prestigious Institute of Medicine of the National Academy of Sciences.

The purpose of today's hearings is to receive the findings and recommendations of that IOM review. Thus, today we have the opportunity to revisit the consensus that arose some 4 years ago and to learn about a new one.

In rethinking the events of 1982, the IOM report simply confirms what consumers, Congressmen, and concerned citizens alike all thought at the time. The report calls nursing home regulation "essential," and credits it as a "positive contribution" towards the cleanup of the nursing home industry. It concludes that government regulation can substantially improve the quality of nursing home life and that a "stronger" Federal regulatory role is necessary. It concedes that nursing home regulation is, in fact, a matter of life and death.

These findings do not mean there is no room for improvement. They do not mean no regulations are ineffective or no longer appropriate. And they do not mean changes cannot or should not be made.

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Indeed, the 1986 consensus we will hear about today indicates that legislative and administrative changes concerning nursing homes are both needed and wanted. But as the IOM consensus makes clear, they are needed and wanted in ways that place resident outcome, not facility input, at the cornerstone of our regulatory system.

The authors of the IOM report have brought us a long way since 1982 in understanding the missteps of the Reagan administration and in developing a more reasoned and reasonable approach to this complex issue. I thank them and their staff for their dedication to this project, for their patience and hard work, and for their participation in today's hearings. I can only hope that both the administration and the Congress will follow the example the study group has set by dedicating their efforts and resources to effecting the recommendations we will learn about today.

Thank you, Mr. Chairman, for recognizing me.

Mr. DINGELL. The Chair thanks the gentleman.

The Chair observes that the report by the Institute of Medicine calls for effective use of the resources for government intervention to promote the safe and effective care for all nursing home residents, and to protect their basic rights.

The system should look directly at what is happening to those residents, and require everyone to attend to them. If the concept is adopted, the Institute of Medicine concludes we can refocus the whole nursing home industry on the residents.

This is a long overdue reform, and the Institute is certainly to be commended for the report and for the recommendations which we regard as of vital importance.

Until now, both the laws and the rules sought only to increase and improve the resources for nursing home care. For the first 10 years of Medicare and Medicaid, the Congress sought to eliminate firetraps and upgrade staffing.

The massive flow of money converted the unsafe and unregulated homes of the 1960's into a firmly established nursing home industry. But we did little to improve the care of residents.

By 1974, a small group of visionaries, including Dr. Katz, who will testify today—and Dr. Katz, we are very pleased that you are with us today—convinced the Department of Health and Human Services that if nursing home regulation did not look at the residents themselves, compliance with the rules would not assure good care for residents.

For the last 10 years, there has been slow but steady progress in State government, in the Health Care Financing Administration, and in parts of the nursing home industry toward adopting a resident-oriented system for protecting nursing home residents.

In 1980, the Health Care Financing Administration signed a consent order in Federal court agreeing to implement an enforcement system based on patient or resident assessment.

In 1981, this committee had to step in to prevent a radical reversal of progress. The White House, as part of so-called regulatory reform, proposed to deregulate nursing homes. Congress was forced to enact a moratorium on deregulation.

Following the moratorium, the Health Care Financing Administration, responding to both consumers and the industry, agreed to

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seek advice from the Institute of Medicine and voluntarily to suspend plans to deregulate.

The advice which was sought is now available to the Nation, and we believe will be very helpful.

The committee is very grateful to the Institute of Medicine for conducting this study. Without this effort to build a strong consensus among the industry, residents' advocacy groups, State regulators, and independent experts, no one would be optimistic about nursing home reform.

But thanks to the Institute of Medicine, the goal that has eluded us for over 10 years seems attainable, and a rational program of addressing the care, rights and the well-being of the residents of the institutions appears to be now within the grasp of the Federal Government.

Mr. Bilirakis wished to be present for this hearing, but regrettably was required to be absent for business in his district, and he has asked that the record be held open for him to submit a statement, and the Chair will do so in full recognition of the fact that Mr. Bilirakis is a very valuable member of the committee.

The findings and recommendations of the Institute will be presented by the chairman of that group, Dr. Sidney Katz, associate dean of the school of medicine at Brown University.

Dr. Katz, we are delighted you are with us this morning. He will be accompanied by Mrs. Judith Brown, vice president of professional services of ARA Centers, based in Houston, TX. We would appreciate if you would come forward, also. Mrs. Patricia Butler, attorney and consultant to the Colorado State Health Department, and she will be present also at the table; as will Mrs. Iris Freeman, director of Nursing Home Residents' Advocates in Minneapolis, MN, and if you also come forward to the witness table; and Mr. Maurice May, chief executive officer of the Hebrew Rehabilitation Center for the Aged in Massachusetts, and he will be also present at the witness table; as will Ms. Dana Petrowsky, chief, division of health facilities, Iowa State Department of Health.

The Chair wants to thank all of our panel members being with us today, and the Chair is keenly aware of the fact that you all had to travel great distances to be with us today, and the efforts you put together in putting together this study, and ladies and gentlemen, if you will come forward to the witness table.

We will hear first the statement of Dr. Katz and receive such comments that the other panel members might choose to give.

[The opening statement of Hon. Michael Bilirakis follows:]

OPENING STATEMENT OF CONGRESSMAN MICHAEL BILIRAKIS

Mr. Chairman, I am tremendously disappointed at my inability to participate in today's joint hearing on nursing home regulation, but appreciate the opportunity to place a statement in the record on this most timely and important subject.

As you know, Mr. Chairman, this is an area in which I have a great deal of interest and concern, for it directly affects my largely elderly constituency and State. Long-term care for the elderly is, no doubt, one of the most crucial areas currently facing us, and hearings like this one are certainly beneficial in helping us to collect the data that will be necessary for us to enact legislative reforms to improve care and treatment of our elderly.

The conclusions which the Institute of Medicine has gathered from their study on nursing home regulation will greatly facilitate our task by giving us the benefit of their opinion on the areas in which nursing homes are, indeed, adequately and ap-

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propriately meeting the needs of their residents and, more importantly, where they are not.

The report has concluded that, while many of the 15,000 nursing homes participating in the Medicare/Medicaid Program provide their residents with appropriate care, many others are greatly lacking in the quality of care they provide and may even contribute to the physical, mental, and emotional deterioration of the residents who are dependent upon them.

It is my strong belief, Mr. Chairman, that there is no room for flaws or inadequacies when we are dealing with the direct health and well-being of people, especially that of the often frail, weak, or ill elderly who need care and compassion to enjoy their "golden years."

Mistreatment and abuse, both of which have been known to occur, of individuals who have entrusted their very lives to facilities that are government-certified and government-subsidized, Mr. Chairman, is absolutely inexcusable and must be eliminated as soon as possible! The report which we will receive today will, I am certain, go a long way in helping us improve the quality of life of nursing home residents, Mr. Chairman, and I look forward to working together to quickly realize same.

Thank you, Mr. Chairman.

Mr. WAXMAN. I would like to ask unanimous consent that chapter 1 of the IOM study, which includes a summary of the conclusions and recommendations, be made a part of the record.

Mr. DINGELL. Without objection, so ordered, [See p. 44.]

Mr. PEPPER. Mr. Chairman, may I, at this point in the record, call attention to "The Rights of America's Institutionalized Aged: Lost in Confinement," a hearing before the Subcommittee on Health and Long-Term Care of the Select Committee on Aging of the House, a public document, a released September 18, 1985.

Mr. DINGELL. Certainly. The Chair will observe that the distinguished gentleman from Florida and his committee and his subcommittee, now because he was formerly the chairman on Committee on Aging before he became chairman of the Rules Committee, has been most valuable in assuring the protection of the rights of residents of nursing homes.

Dr. Katz.

STATEMENT OF SIDNEY KATZ, M.D., CHAIRMAN, COMMITTEE ON NURSING HOME REGULATION, INSTITUTE OF MEDICINE, AND ASSOCIATE DEAN OF MEDICINE, BROWN UNIVERSITY, ACCOMPANIED BY DANA L. PETROWSKY, CHIEF, DIVISION OF HEALTH FACILITIES, IOWA STATE DEPARTMENT OF HEALTH; IRIS FREEMAN, DIRECTOR, NURSING HOME RESIDENTS' ADVOCATES; DAVID TILSON, STAFF DIRECTOR, INSTITUTE OF MEDICINE, BROWN UNIVERSITY; PATRICIA BUTLER, COUNSEL AND CONSULTANT, COLORADO STATE HEALTH DEPARTMENT; JUDITH BROWN, ARA LIVING CENTERS; AND MAURICE I. MAY, CHIEF EXECUTIVE OFFICER, HEBREW REHABILITATION CENTER FOR THE AGED

Dr. KATZ. Mr. Chairman, and members of the committee, my name is Sidney Katz. My training was in internal medicine, and I have worked in geriatric medicine doing research, teaching, and also taking care of elders for more than 30 years.

I am currently associate dean of the school of medicine at Brown University and director of the Brown University Gerontology Center.

I am pleased to be here this morning to tell you about the results of the study recently completed by the Institute of Medicine Com-

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mittee on Nursing Home Regulation, which I had the privilege of chairing.

The Honorable Chairman Dingell has introduced the members of the panel accompanying me here at the table. A full copy of my statement has been submitted, and this morning, I will review the highlights of our report, and then all of us will be available to answer your questions.

I wish to acknowledge with deep appreciation the dedication and hard work of the committee, and also to express appreciation for the diligent efforts of David Tilson and the Institute of Medicine staff.

As you have heard, the origin of our study is well known to all of you. HCFA asked the Institute of Medicine to undertake this extensive review of Federal and State regulation of nursing homes after Congress had expressed strong concern about changes in Federal policies proposed by the administration.

Our committee was composed of 20 people with diverse backgrounds, professional training, and experience. We produced a report that recommends profound changes in the system for regulating nursing homes.

The recommendations are supported by all members of the study committee. We believe that if these recommendations are implemented by the Congress, the executive branch, and the States, the quality of care and quality of life for many thousands of nursing home residents will improve substantially.

While many of the 15,000 nursing homes participating in the Medicaid and Medicare Programs provide residents with appropriate care and considerate support, the committee found that in many other government-certified nursing homes, individuals receive very inadequate, sometimes shockingly deficient, care that is likely to hasten the deterioration of their physical, mental, and emotional health.

The current regulatory system is unable to improve or eliminate substandard facilities, the underlying circumstance that prompted the study.

Federal policies that guide the current regulation of nursing homes are relatively recent. Although Medicare and Medicaid was passed in 1965, the regulations for nursing facilities were not issued in final form until 1974.

From the outset, it was recognized the regulations were seriously flawed. Moreover they were administered and enforced very unevenly by the States. Proposals were made to modify them in the late 1970's, but they were not approved; and the regulations remain today much as they were when originally issued.

The current regulations consist of three interrelated components: Performance criteria—standards; a monitoring process by the States, and enforcement policies and procedures to assure compliance with the standards.

The three components are analogous to the legs of a three-legged stool; all are essential. There are major problems with the three components of the regulations, but most are remediable and we think we have recommended remedies that will work.

Performance criteria are called "conditions of participation" and "standards" in the regulations. There are two sets of criteria, one

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for skilled nursing facilities and another for intermediate care facilities. We do not think that maintaining two sets of criteria is justifiable.

In addition, the underlying logic of the current criteria is unsound. They are based on the assumption that the potential capability and written intent of the facility to provide appropriate care is sufficient to ensure that adequate care is actually being provided.

We think that the standards need to be completely overhauled so that they focus primarily on the care that is actually being provided to residents and the directly observed effects of that care, rather than on capacity, written intent to comply with the standards, as is currently the case.

In addition, important performance criteria need to be added dealing with quality of care, quality of life, and minimum training requirements for the primary caregivers, namely, the nurse's aides who provide perhaps 90 percent of the hands-on care to residents.

Our recommendation there is to do away with the two levels of care and to require all nursing homes to adhere to a single set of upgraded standards.

The levels of disability and services required by residents in intermediate care facilities are similar to those in skilled nursing facilities; and need for supervision of aides by skilled R.N.'s and licensed practical nurses is important in all facilities.

The next major recommendation is far reaching in importance. We recommend that all nursing homes be required to make standard assessments of all residents on admission and periodically thereafter, and to record the data in a standard way in residents' records.

Standard resident assessment data across facilities will establish norms that are currently not available—descriptions of services and well being for residents who have similar characteristics.

This resident assessment data will give inspectors an objective basis for comparisons of the quality of care, and the functional aspects of quality of life.

Such assessment will also give nursing home managers a useful tool that most do not now have. Competent assessment of each resident's functional, medical, mental, and social status is essential to plan a program of care that is individually tailored to the resident's needs.

Other important recommendations concerning the performance criteria are to add new conditions of participation on quality of care of quality of life, to rewrite the existing conditions in order to make them more resident-centered and outcome-oriented, to give additional emphasis to residents' rights by raising them from a standard to a condition of participation, to require training for nurse's aides, to prohibit discrimination against residents supported by Medicaid, and to strengthen the social service staffing requirement.

Let us turn to the second leg of the three-legged stool, the processes used to monitor the performance of nursing homes. The monitoring activities include:

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Survey certification inspections of each nursing home at least once a year, by the State, that primarily focus on the capacity of the facility.

Inspection of care reviews conducted either by the State Medicaid agency, the State licensure and certification agency, or a professional review organization.

Investigations of complaints by residents, staff, families of residents, ombudsmen, or other third parties. Complaints cover resident abuse, inadequate care, violations of residents' rights, or other types of unacceptable behavior by nursing home staff or management. Complaints often involve violations of Federal conditions of participation or standards.

The committee identified needs for changes in current regulations, policies, and procedures governing the current monitoring processes.

First, major changes in the process are needed as a result of the previously recommended changes in performance standards.

Second, changes are needed to deal with serious problems in relationship between the Federal and State monitoring functions and to deal with problems of coordination among State functions.

Third, changes are required because of serious limitations in the ability of Federal and State regulatory agencies to carry out their responsibility, primarily inadequate funding to provide sufficient number of appropriately qualified, properly trained, and adequately supervised surveyors.

Finally, changes are needed with regard to the following operational issues:

Predictability. Nursing home operators can usually predict the timing of an annual survey because certification is in effect for exactly 12 months. Thus, an operator of a substandard facility can hire extra staff, stock up, improve menus, clean up, bring the records up to date, and take other necessary action to bring the facility into temporary compliance.

Inefficiency. All nursing homes, regardless of their past record of compliance, are surveyed in the same way. A more efficient process would permit the survey agency to spend more time in poor facilities than in good ones.

Paper compliance. Compliance is frequently determined on the basis of record reviews rather than direct observation.

Insensitivity to resident needs. The current survey process makes no allowance for the substantial diversity among residents and among facilities. All are surveyed in the same way.

Inconsistency. States may vary greatly in the ways that they conduct surveys. Substantial inconsistencies exist in findings and judgments of individual surveyors within States and across States.

Isolation from related monitoring processes. Only 17 States combine or relate the findings of inspection of care reviews with the survey certification process. In some States, there is little or no sharing of information between the survey process and the processes for monitoring and investigating complaints.

Variable State regulatory capacity. There are very large differences in the level of funding and staffing, the types and numbers of personnel used, and the length of time spent in inspecting facilities.

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The committee made recommendations designed to deal effectively with each of these problems. We recommend making the timing of the surveys more flexible and less predictable.

We recommend a two-stage survey approach that is based on installation of the standard resident assessment system discussed earlier. A relatively short survey would be conducted of residents, and staff, using an instrument that relies on key outcome indicators.

If the results of the short survey indicate that quality of care and quality of life are satisfactory, the facility would be certified.

If the standard short survey uncovers problems, a more detailed survey would be conducted. We recommend that the survey process be integrated with inspection of care, and be coordinated with the complaint program.

We also recommend that HCFA encourage the States to use positive incentives by recognizing and rewarding superior performance.

A substantial effort is recommended to ensure that the instruments and protocols are valid and reliable and that the surveyors be properly trained.

We also believe it is important that Federal surveyors inspect State-owned facilities to ensure that the same performance standards be observed by State-owned facilities as are required for privately owned facilities.

The third leg of our three-legged regulatory stool is enforcement. It is clear that even with improved standards and more effective monitoring procedures, it is unlikely that the performance of marginal or unsatisfactory facilities will improve unless compliance with the standards is effectively enforced.

In order to remedy the problem, we must deal with, one, Federal and State attitudes toward enforcement, as reflected in the regulations; two, Federal rules and procedures regarding enforcement; three, State variations in enforcement authority, policies, and procedures; and, four, inadequate Federal and State resources for enforcement.

To deal with these problems, we have recommended that HCFA revise its enforcement guidelines to the States to specify that survey agency personnel not be used as consultants to providers with compliance problems; specify how to evaluate plans of correction and what constitutes an acceptable plan of correction; specify the circumstances under which formal enforcement actions should be initiated, and how they should be undertaken; and require that States have formal enforcement procedures and mechanisms.

We recommended that the Medicaid legislation be amended to authorize a standard set of intermediate sanctions. These should include a ban on admissions, civil fines, receivership, and emergency authority to close facilities and transfer residents.

Authority to impose severe sanctions on chronic violators should also be provided.

Moreover, for the really bad facilities, the legislation should be amended to make the appeals process on sanctions less attractive. Finally, we recommend that HCFA strengthen enforcement capabilities.

While effective regulation is essential, it is not sufficient to ensure adequate quality of care and quality of life in nursing homes. Other important factors are: Consumer involvement; com-

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munity involvement within nursing homes; positive motivation and technical competence of ownership; and a professional climate that will attract highly motivated, ethical and well-qualified staff, supported by the industry and by educational and professional institutions.

We recommend that the Ombudsman Program, which is authorized by the Older Americans Act, be strengthened both by amending the legislation and by recommending that the Administration on Aging give it much stronger and more effective leadership.

We offer suggestions in the other areas, including the introduction of incentives for rewarding consistently high quality care; for example, preference for institutions with a good record when awarding certificates of need for constructing new facilities or expanding existing ones.

Finally, we identified issues that need further study; the scope and design of information systems needed to regulate nursing homes effectively and to facilitate development of sound policies for long-term care; policies governing the method and amounts of payment to nursing homes for care of residents eligible for support under the Medicaid Program; policies affecting the supply of nursing home beds in the context of the growing demand for all types of long-term care services; regulatory policies concerning the training and qualifications of all staff in nursing homes; minimum staffing patterns needed to provide adequate care; and policies governing construction for new nursing homes, specifically, the proportion of single rooms that should be required.

I have tried to provide you with the main points in our comprehensive report. Our principal concern is for the nursing home residents, a segment of the population which often cannot speak effectively for itself.

If the Congress, the executive branch, the State governments, the industry, and the consumers find it useful and persuasive, we feel richly rewarded for our efforts.

My colleagues and I will be pleased to answer questions concerning the report and its recommendations.

[Testimony resumes on p. 25.]

[The prepared statement of Dr. Katz follows:]

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Statement by Dr. Sidney Katz
at a Joint Hearing of the Subcommittees on Health and the Environment and Oversight and Investigations of House Committee on Energy and Commerce and Health and Long-Term Care Subcommittee of House Select Committee on Aging, March 25, 1986

Mr. Chairman and members of the committees. My name is Sidney Katz. My training was in internal medicine; and I have worked in geriatric medicine, doing research, teaching and patient care in that field for more than 30 years. I am currently Associate Dean of the School of Medicine at Brown University in Providence, R.I., and Director of the the Brown University Gerontology Center.

I am pleased to be here this morning to tell you about the results of the study recently completed by the Institute of Medicine Committee on Nursing Home Regulation which I had the privilege of chairing. With me this morning are five members of the committee - Patricia Butler, an attorney and consultant to the Colorado Health Department; Dana Petrowsky, Chief, Division of Health Facilities in the Iowa Department of Health; Iris Freeman, Director of Nursing Home Residents' Advocates in Minneapolis; Judith Brown, Vice President of Professional Services of ARA Living Centers; and Maruice May, Chief Executive Officer of the Hebrew Rehabilitation Center for the Aged in Boston. I will give you the highlights of our report and then all of us will be available to answer your questions. Before I begin, I wish to acknowledge with deep appreciation the dedication and hard work of the committee. I also wish to express appreciation for the diligent efforts of David Tilson and the Institute of Medicine staff.

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The origin of our study is well known to all of you. HCFA asked the Institute of Medicine to undertake this extensive review of federal and state regulation of nursing homes after Congress had expressed strong concern about changes in federal policies proposed by the Administration. Our committee was composed of 20 people with diverse backgrounds, professional training, and experience. We produced a report that recommends profound changes in the system for regulating nursing homes. The recommendations are supported by all members of the study committee. We believe that if these recommendations are implemented by the Congress, the Executive Branch, and the states, the quality of care and quality of life for many thousands of nursing home residents will improve substantially.

While many of the 15,000 nursing homes participating in the Medicaid and Medicare program provide residents with appropriate care and considerate support, the committee found that in many other government-certified nursing homes, individuals receive very inadequate--sometimes shockingly deficient--care that is likely to hasten the deterioration of their physical, mental, and emotional health. The apparent inability of the current regulatory system to improve or eliminate substandard facilities is the underlying circumstance that prompted this study.

Federal policies that guide the current regulation of nursing homes are relatively recent. Although the Medicare and Medicaid was passed in 1965, the regulations for Skilled Nursing Facilities and

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Intermediate Care Facilities were not issued in final form until 1974. From the outset, it was recognized by most interested parties that the regulations were seriously flawed. Moreover, they were administered and enforced very unevenly by the states. Proposals were made to modify them in the late 1970s, but they were not approved; and the regulations remain today much as they were when originally issued.

The main purpose of current federal nursing home regulations is to ensure that nursing home residents receive adequate care in a safe, clean facility and that they are not deprived of their civil rights. The regulations consist of three interrelated components: performance criteria (standards), a monitoring process by the states, and enforcement policies and procedures to assure compliance with the standards. The three components should be thought of as analogous to the legs of a three-legged stool: all are essential. There are major problems with the three components of the regulations, but most are remediable and we think we have recommended remedies that will work.

Performance criteria are called "conditions of participation" and "standards" in the regulations. There are two sets of criteria, one for Skilled Nursing Facilities and another for Intermediate Care Facilities. We do not think that maintaining two sets of criteria is justifiable.[1] We also find that the underlying logic of the current criteria is unsound. They are based on the assumption that the potential capability and written intent of the facility to provide appropriate care is sufficient to ensure that adequate care is

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actually being provided. We think that the standards need to be completely overhauled so that they focus primarily on the appropriateness of the care that is actually being provided to residents and the directly observed effects of that care on residents, rather than on a facility's apparent capacity to provide care and its written intent to comply with the standards, as is currently the case. In addition, important performance criteria need to be added dealing with quality of care, quality of life, and minimum training requirements for the primary caregivers, namely, the nurse's aides who provide perhaps 90 percent of the hands-on care to residents.

Our recommendation is to do away with the two levels of care and to require all nursing homes to adhere to a single set of upgraded standards. We are aware that 43 percent of all nursing homes are now Intermediate Care Facilities, and that this recommendation may entail added costs, at least in some states. The evidence is strong that this recommendation is necessary to ensure that adequate quality of care and life is provided to residents in ICFs. The levels of disability and services required by residents in intermediate care facilities are similar to those in skilled nursing facilities; and need for supervision of aides by skilled RNs and licensed practical nurses is important in all facilities.

The next major recommendation is far reaching in importance. We recommend that all nursing homes be required to make standard assessments of all residents on admission and periodically thereafter, and to record the data in a standard way in the official

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medical records. Standard resident assessment data across facilities will establish norms that are currently not available (descriptions of services and well-being for residents who have similar characteristics). This resident assessment data will give inspectors an objective basis for comparisons of the quality of care, also of the functional aspects of quality of life. More effective and valid regulation will be facilitated and a powerful means for identifying deficient homes will be provided. Such assessment will also give nursing home managers a useful tool that most do not now have. Competent assessment of each resident's functional, medical, mental, and social status is essential to plan a care program individually tailored to the resident's needs. Moreover, the introduction of this system is likely to have a positive effect on the attitudes and behavior of nursing home staff at all levels.

Other important recommendations concerning the performance criteria are to add new conditions of participation on quality of care and quality of life, to rewrite many of the existing conditions in order to make them more resident-centered and outcome-oriented, to give additional emphasis to residents' rights by raising them from a standard to a condition of participation, to require training for nurse's aides, to prohibit discrimination against residents supported by Medicaid, and to strengthen the social service staffing requirement.

Let us now turn to the second leg of the 3-legged stool -- the processes used to monitor the performance of nursing homes. The monitoring activities include:

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- Survey certification inspections of each nursing home at least once a year, conducted by staff of the state licensure and certification staff, and primarily focused on the capacity of the facility;
- "inspection of care" reviews conducted either by the state Medicaid agency, the state licensure and certification agency, or a professional review organization;
- investigations of complaints by residents, staff, families of residents, ombudsmen, or other third parties. (Complaints cover resident abuse, inadequate care, violations of residents' rights, or other types of unacceptable behavior by nursing home staff or management. Complaints often involve violations of federal conditions of participation or standards.)

The committee identified needs for changes in current regulations, policies, and procedures governing the current monitoring processes. First, major changes in the process are needed as a result of the previously recommended changes in performance standards. Second, changes are needed to deal with serious problems in relationship between the federal and state monitoring functions and to deal with problems of coordination among state functions. Third, changes are required because of serious limitations in the ability of federal and state regulatory agencies to carry out their responsibility -- primarily inadequate funding to provide sufficient numbers of appropriately-qualified, properly-trained, and adequately-supervised surveyors.

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Finally, changes are needed with regard to the following operational issues:

Predictability. Nursing home operators can usually predict the timing of an annual survey because certification is in effect for exactly 12 months. Thus, an operator of a substandard facility can hire extra staff, stock up, improve menus, clean up, bring the records up to date, and take other necessary action to bring the facility into temporary compliance.

Inefficiency. All nursing homes, regardless of their past record of compliance, are surveyed in the same way. A more efficient process would permit the survey agency to spend more time in poor facilities than in good ones.

Paper compliance. Compliance is frequently determined on the basis of record reviews rather than direct observation.

Insensitivity to resident needs. The current survey process makes no allowance for the substantial diversity among residents and among facilities. All skilled nursing facilities and all intermediate care facilities are surveyed in the same way.

Inconsistency. States may vary greatly in the ways that they conduct surveys. Substantial inconsistencies exist in findings and judgments of individual surveyors within states and across states.

Isolation from related monitoring processes. Only 17 states combine or relate the findings of inspection of care reviews with the survey certification practice. In some states, there is little or no sharing of information or coordination of activities between the

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survey process and the processes for monitoring and investigating complaints.

Variable state regulatory capacity. There are very large differences in the level of funding and staffing, the types and numbers of personnel used, and the length of time spent in inspecting facilities.

The committee made recommendations designed to deal effectively with each of these problems. We recommend making the timing of the surveys more flexible and less predictable. We recommend a two-stage survey approach that is based on installation of the standard resident assessment system discussed earlier. A relatively short, standard survey would be conducted by observing and talking to a case-mix-referenced sample of residents -- and staff -- using an instrument that relies on key outcome indicators. If the results of the standard survey indicate that quality of care and quality of life are satisfactory, the facility would be certified. If the standard survey uncovers problems, an extended survey -- longer and more detailed -- would be conducted. We recommend that the survey process be integrated with inspection of care, and be coordinated with the complaint program. We also recommend that HCFA encourage the states to use positive incentives by recognizing and rewarding superior performance.

A substantial effort will be necessary to ensure that the instruments and protocols are valid and reliable and that the surveyors be properly trained in their use. We recommend that HCFA

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assist the states in these areas and insist that states perform adequately.

We also believe it is important that federal surveyors inspect state-owned facilities to ensure that the same performance standards be observed by state-owned facilities as are required for privately-owned facilities.

The third leg of our three-legged regulatory stool is enforcement. It is clear that even with improved standards and more effective monitoring procedures, it is unlikely that the performance of marginal or unsatisfactory facilities will improve unless compliance with the standards is effectively enforced. The committee found that inadequate enforcement seems to be a problem everywhere. In order to remedy the problem, we must deal with (1) federal and state attitudes toward enforcement, as reflected in the regulations, (2) federal rules and procedures regarding enforcement, (3) state variations in enforcement authority, policies, and procedures, and (4) inadequate federal and state resources for enforcement.

To deal with these problems we have recommended that HCFA revise its enforcement guidelines to the states to:

- specify that survey agency personnel not be used as consultants to providers with compliance problems;
- specify how to evaluate plans of correction and what constitutes an acceptable plan of correction;
- specify the circumstances under which formal enforcement action should be initiated, and how they should be undertaken;

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- require that states have formal enforcement procedures and mechanisms.

We recommend that the Medicaid legislation be amended to authorize a standard set of intermediate sanctions that can be used by both state and federal governments. This should include ban on admissions, civil fines, receivership, and emergency authority to close facilities and transfer residents. Authority to impose severe sanctions on chronic violators should also be provided. We estimated that perhaps 10-15 percent of facilities fall into this category of repeat violators. Present statutory authority is not adequate to deal with these facilities. Moreover, for the really bad facilities, the legislation should be amended to make the appeals process on sanctions less attractive. Finally, we recommend that HCFA strengthen enforcement capabilities.

While effective regulation is essential, it is not sufficient to ensure adequate quality of care and quality of life in nursing homes. Other important factors are: consumer involvement; community involvement within nursing homes; positive motivation and technical competence of ownership, management and staff; and a professional climate that will attract highly motivated, ethical, and well-qualified staff (supported by the industry and by educational and professional institutions).

We recommend that the ombudsman program, which is authorized by the Older Americans Act, be strengthened both by amending the legislation and by recommending that the Administration on Aging give

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it much stronger and more effective leadership. We offer suggestions in the other areas, including the introduction of incentives for rewarding consistently high quality care -- for example, preference to institutions with a good record when awarding certificates of need for constructing new facilities or expanding existing ones.

Finally, we identified issues that need further study: the scope and design of information systems needed to regulate nursing homes effectively and to facilitate development of sound policies for long-term care; policies governing the method and amounts of payment to nursing homes for care of residents eligible for support under the Medicaid program; policies affecting the supply of nursing home beds in the context of the growing demand for all types of long-term care services; regulatory policies concerning the training and qualifications of all staff in nursing homes; minimum staffing patterns needed to provide adequate care; and policies governing construction for new nursing homes, specifically, the proportion of single rooms that should be required.

I've tried to provide you with the main points in our comprehensive report. I know I can speak for my colleagues when I say that both the committee and staff worked very hard to make the report as thorough, thoughtful, and responsible as possible. Our principle concern is for the nursing home residents, a segment of the population which often cannot speak effectively for itself. If the Congress, the Executive Branch, the state governments, the industry and the consumers find it useful and persuasive, we feel richly rewarded for our efforts.

My colleagues and I will be pleased to answer questions concerning the report and its recommendations.

Thank you.

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Mr. WAXMAN [presiding]. Thank you, Dr. Katz.

It is clear from the report and from the comments you have just made that the underlying basis for the committee's findings and recommendations is its belief that nursing homes should be evaluated more in terms of how their residents are doing, rather than what the facilities look like, how they are staffed and how they keep records. That is, the real test by which Medicare and Medicaid should examine nursing homes is the extent to which they maintain or improve residents' functional and psychosocial health.

The report also makes clear that this type of examination can only be performed if residents are properly and periodically assessed in terms of their functional medical, mental, and psychosocial status.

I understand you have done quite a bit of work on this question of resident assessment. Would you please explain to the Members why such an assessment is so important, and just how it would work?

Why is it important for nursing homes to use a standardized assessment tool, and how difficult is it to develop and implement a standardized assessment mechanism?

Dr. KATZ. Thank you.

An important test of the strength of the program of care is to look at how well—is to look at how well the resident is. The measure of how well cannot be thought of in the nursing home as only as solely the correct diagnosis of a heart attack.

The nursing home, as the word home says, is a place in which both care and living take place, and the measure of, or an important measure of the well-being is the functional integrity of that individual.

The World Health Organization, back in the 1950's, talked of well-being as expressed through measures of physical, social, and psychological functioning. It has taken us almost 30 years to start to be able to measure those well-beings.

In the nursing home, the well-being of a resident is expressed through whether the individual gets better or not in these functional terms, remains the same, or gets worse, and one needs a standard of getting better, getting worse, or remaining the same for that nursing home resident.

Most nursing home residents do not get better in very large ways. There is a slow, diminishing course that they run in terms of functional well-being.

Now, we can measure those things, and I don't want—unless you are interested later—to go into a speech. In the absence of that kind of measure of those individuals, we turn to medical well-being, how much disease, which is the judgment of someone else.

We turn to the processes of care, and the processes of care, they may be right, we may be getting good care for infections or skin sores, but in terms of the view of a professional, but we need to translate that into the well-being of the clients themselves. It is in that realm of measurement that we are concerned.

Now, with another part of your question, you asked why do we need standard assessment across settings. One of the best ways of looking at whether an individual resident is following the correct course of a downhill decline, if you can follow that very difficult

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concept, is to look at what most people of that sort are experiencing around the country.

It is a comparison with what we call norms. Without that, we would have to rely on academic experiments, which can't be conducted in a dynamically changing situation of technology. We won't have the answers, and the likelihood is that we—I feel personally that there is a very strong likelihood that we can put these systems in place, begin to right now.

They won't be the final answers. They will have to be improved over time, but we can put these systems in place. Not only can we put them in place, and this is dealing with the other aspect, what makes us think they could do this kind of assessment?

It is essential that nursing homes themselves, in order to monitor their own effectiveness, have that kind of information about the individual residents, so they would be able to use those for management purposes.

I feel we do have the tools—one would run into academic arguments among academicians as to what is better or worse, but we can make a beginning, and we can make a big difference.

If we don't, I predict we are going to chase our tail. We are still going to look at the process and judgments without any standard to compare these judgments again on the part of every individual, and without any handle on it in terms of a public approach.

Mr. WAXMAN. I understand the Health Care Financing Administration shares the committee's view that the nursing home surveying process should focus more on the provision of services and on resident outcomes. Accordingly, it has developed a new "patient care and services system," which it would like to implement this spring.

Your committee did not endorse this new system, and indeed, the committee cited several deficiencies with the system.

Maybe Ms. Freeman or Ms. Petrowsky can answer this. Would you explain the committee's view on the PaCS Program. Is it something we should build on? Do you believe HCFA should implement this program this spring or abandon it and follow the recommendations of the Institute of Medicine, which have been presented today?

Ms. PETROWSKY. PaCS is widely regarded as an improvement over the current survey process we use. The committee didn't go far enough, for instance, the sampling protocol is not scientific and does not allow you to compare facilities to other facilities.

There is no rational basis for that. It relies on unguided surveys or judgment, and doesn't give you the criteria for evaluating a facility to the extent that there is going to be any kind of consistent interpretation or enforcement of the standards, and those are two rather basic issues.

Ms. FREEMAN. There is some compatibility between the intent of the new long-term care service process which has been called PaCS, and the resident involvement in the survey delivered by the Institute of Medicine report.

We believe that because some of the developmental work toward involving the resident in the evidence of the survey has already taken place, that some of the inevitable cost accounting for changes

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through the Institute of Medicine recommendations will have already been spent.

There is work going on that is in keeping with the spirit and the intent of the Institute of Medicine recommendations for resident involvement.

Mr. WAXMAN. Thank you very much.

Mr. Pepper.

Mr. PEPPER. Yes, thank you, Mr. Chairman.

If I may, I wish to congratulate and thank your great institution for this magnificent study that you made. If you can imagine anybody happy with bedsores or in scalding water, why, maybe the criterion would be happiness on the part of these people in nursing homes.

Doctor, what percentage of the nursing homes in the country are private, or for-profit, and what are non-profit nursing homes?

Dr. KATZ. Let me ask for one of the staff to give us a detail of that sort.

Mr. TILSON. My name is David Tilson, staff director; 70 percent of the facilities operated by forprofit operators and 80 percent of the beds.

Mr. PEPPER. You said 70 percent profit and 30 percent nonprofit.

Dr. KATZ. Yes.

Mr. PEPPER. I was very much attracted to a statement that you made that the Government should be in the position to impose civil fines. These people respect the requirement to pay money, and that kind of punishment can be meted out by regulation, I suppose, rather than having to go through a court trial.

Do you think that the Federal Government, which pays half, about 50 percent of the cost of patients in nursing homes, has adequately inspected or adequately concerned itself about the quality of care that those people get?

Dr. KATZ. Pat Butler.

Ms. BUTLER. The committee felt that the Federal Government and the States, both, have fallen short in their responsibility to monitor quality of care, and in particular, we felt that the Federal Government ought to take a much stronger role both in financing, and in setting uniform set of standards, procedures for the States to follow in accomplishing quality assurance purposes.

Mr. PEPPER. That would include the promulgation of regulations that require effective administration, the kind of administration that assures quality of care?

Ms. BUTLER. Exactly, and we gave a number of specific examples by which we thought that the relationship between the Federal Government and the States could be improved.

Mr. PEPPER. So, far from diminishing Federal concern about the care of people in nursing homes, we need to increase Federal concern, increase Federal regulation, and increase Federal effectiveness in enforcement?

Ms. BUTLER. Yes, that is definitely the committee's answer.

Mr. PEPPER. That is your opinion, Doctor?

Dr. KATZ. It is.

Mr. PEPPER. It occurred to me during the time you were giving your valuable testimony that if the States and the Federal Government substantially share evenly the cost of caring for people in

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nursing homes, we both have a responsibility to see to it that the people that we put there and sustain there are properly cared for, and especially since the Federal Government, if I am correct, pays about 75 percent of the cost of the State inspections.

Is that your understanding?

Ms. BUTLER. That is right.

Mr. PEPPER. Now then, the Federal Government, if it pays half of the cost of a patient being in the nursing home and more than half of the cost of inspection, we are very much concerned about what kind of inspections are being given to those nursing homes.

Is it generally the custom of the proprietors of nursing homes to post in these nursing homes a bill of rights for patients that are there?

Ms. FREEMAN. Throughout the process of the study, we discovered no end to variability in the practices of nursing home operators and staff. There is an expectation that residents will be informed of their rights both under Federal regulation, and any rights that exist under State laws and State regulations, and sometimes residents are advised of both by verbal information and both by a posted law.

Often, they are not. Recommendations in the study are geared to assuring that in all situations, people will be aware that there are rights, know what those rights are, and will know how to seek redress when those rights are compromised or violated.

Mr. PEPPER. You spoke of the ombudsman factor, maybe some procedure like that should be developed so someone could come in and champion the people in the nursing home.

Back over the years, my committee, either the Committee on Aging or our Subcommittee on Health and Long-Term Care, had some of the most abominable facts brought to our attention.

All the toothbrushes of the people in the nursing home thrown in a bucket, all of the falseteeth thrown in a bucket; look around in there, find yours?

People permitted to sit all day in their own feces, an unsanitary situation.

Sometimes brutality inflicted upon them. Elderly people who have been in poor health, strength, left alone with some inexperienced person through the night, unaware of how to treat some emergency that might arise for that individual.

If this 70 percent are privately owned, and I am not complaining about the nursing homes being owned by private people, that is all right. But if they know that if they don't keep a high standard, the Government of the United States is going to stick a fine on them that will hurt, they will be careful to get competent people.

We have had testimony that it wasn't intentional, but unintentional lack of care by untrained people is unexcusable, and helpless nursing home resdients have paid the results.

They will employ competent people, and see that proper care is given to the individuals, or the Government will shut them off, saying we won't allow you to take federally supported patients any more if there is more than one or two violations, frequency of low-quality care, say.

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It occurred to me that it might be that the State and the Federal Government might jointly inspect these nursing homes, since we are both concerned.

Any comment on that?

Ms. PETROWSKY. That is the practice in most States. The Medicare survey agency is usually the State health department, Medicare and Medicaid, that is usually in the State health department, and frequently——

Mr. PEPPER. Do the Federal inspectors inspect all the nursing homes where there are Medicaid patients?

Ms. PETROWSKY. The State health departments inspect for the Federal Government.

Mr. PEPPER. Who does it?

Ms. PETROWSKY. The State health departments.

Mr. PEPPER. I am talking about the Federal Government. You mean the States do it and then report to the Federal Government?

Ms. PETROWSKY. That is correct.

Mr. PEPPER. That is not the same as a Federal inspector.

Ms. PETROWSKY. There are Federal inspectors that look behind the judgments of the State inspectors to ensure——

Mr. PEPPER. But do they go to the nursing home?

Ms. PETROWSKY. Yes, they do.

Mr. PEPPER. Are you telling us that all the nursing homes are presently being visited by Federal inspectors?

Ms. PETROWSKY. No, no, a very, very small percentage.

Mr. PEPPER. That is what I am talking about. That is why I wonder if Federal inspectors should not use the same prerogatives as the State and have both inspect the homes, and maybe the two together can find what needs to be reported.

Well, there is a whole lot we can say. I feel we can keep a lot of people out of nursing homes by adequate home care, and not all the people in nursing homes ought to be there.

Our subcommittee has been concerned for a long time, and so has Mr. Waxman, about long-term care. What are you going to do about these poor people that are not really sick enough to be in a hospital and yet need a home, need to be looked after, with minimum care, but they have got nowhere to live except on the streets in some instances.

In my city, a minister told me there are probably 2,000 to 3,000 people sleeping on the streets. The weather is not as inclement there as it is in many places, but a certain Federal official not long ago said that most of the people that were so-called sleeping in the streets lacked fresh air.

Well, I saw an article in the New York Times along about that time about New York's Union Station. The homeless would gather and sleep on the benches, stay in the halls of the station until about 1:30 in the morning, when the police moved them out because they had to close the station for the night.

One evening, or early one morning, this usual group of the homeless were there, and they noticed one little old lady, white-haired, thin, she didn't seem to have much warm clothing on, no blankets or cover of any kind to speak of, but anyway, it came time for the police to move them out into the cold, and the temperature was 17

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degrees. The next morning, they found the little old lady dead up against a wall. I reckon she just had too much fresh air.

And there are cases like that all over America, and so, one of the problems that we are concerned with is not only home care, where they get more medical assistance and the like, but a place where they can get long-term care, and that, too, is one of the casualties facing our country.

Dr. Katz, as I said, I regret very much that I have to go, but I want to thank you all for performing your usual excellent service for the country. Everyone will respect what you say.

Let us earnestly hope, and I am sure my colleagues, Mr. Waxman and Mr. Dingell, and our other colleagues will do everything we can to induce the Congress and our administrative agencies to carry out your recommendations for the protection of these people, and maybe they will be truly able to respond to an inquiry.

Thank you very much again.

Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Walgren.

Mr. WALGREN. I can only salute the statement of Congressman Pepper, and your own interest, Mr. Chairman, and the thrust of this report seems a very important step in inclining our system towards better care, and maybe that is the best contribution any of us can make.

I certainly do want to express my respect and that of the constituents that I represent, for the effort you have put into it.

Are we far away from being able to define the standards, or to be able to accomplish the standards assessment? As I understand the criticism of this proposal, present proposal by HCFA, PaCS, whatever they call them, the norms are not yet established, and so we are not in a position to immediately implement that or the kind of standards assessment which the report calls for.

How difficult is that to develop, and is there the danger that if you just take the norm that you experience out there now, you are rolling in less than the care that we would want to provide everybody, and therefore, the measure is drawn down. and would indicate that there would be a greater decline than would be acceptable and within the norms, than we ought to be asking of ourselves?

Dr. KATZ. Tall order. We can begin to set in place a specific information system for resident assessment. That can be done now. There would be some debate about the fine points of it.

We can put a set of key indicators in place, this has already been done in some of the States, New York, sent health events. We can produce some consensus among professionals about norms for these key indicators.

Those consensuses being currently—would currently—this is the position I would take, would be better judgments, would be better standards than is currently available, and would be clearer.

They wouldn't be perfect, but better than what is available at this time. HCFA could mount such a consensus, and implementing effort.

I think it would take monitoring and oversight to improve this, and my view is that that oversight should come from elsewhere, such as Congress or congressionally delegated activity, which includes those who would make sure that it didn't or that we didn't

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back track, as you said, to make things worse, and that norms would be developing at the same time.

The norms that would be used by such an oversight professional group would be the best of professional judgments that can be brought to bear today from several sources.

One important one would be some normative information that is already available from some States, such as New York, about what the experience is. I am painting that sort of picture for you.

In its absence, and that monitoring group would also regularly try to make sure that we were upgrading that, because this is a dynamic situation, and technology changes, and we don't want to use standards that die.

Mr. WALGREN. It might also be dynamic that we might find out something that we can get better outcomes than we are presently getting and without a way to compare, we miss the better outcomes.

They don't stand out and catch our attention.

Dr. KATZ. And look at the processes that are related, the processing of management, running a nursing home, et cetera, et cetera.

Mr. WALGREN. So much of this would have to be related to the spirit, the will to engage in life, literally, that by focusing on almost present state, especially including present state of mind, you are going to the driving force of whether somebody has a decent outcome.

Dr. KATZ. Yes, one of the difficulties I have, when you ask the question, and not knowing you, frequently these are thought of as academic points. Academia is not going to give that answer.

No experiment that an academic can run will give us that. It will come from public information, and public knowledge, that is what we are talking about. We have something to contribute from academia, types of information, and what we have learned about effectiveness and noneffectiveness, but that is not enough on which to build a total public system.

Mr. WALGREN. Let me ask you to characterize the present enforcement system. It is our understanding that it is just shot through with lack of enforcement, and therefore, provides no comfort to the conscience of the public that the right thing is happening in a whole lot of nursing homes across the country.

Dr. KATZ. Let me ask Pat Butler to address this, and supervised many of the activities of the staff in this area.

Ms. BUTLER. I am afraid you do characterize the current enforcement system. It is seriously flawed because originally, when the regulations went into effect over 10 years ago, there was a great concern to bring facilities into the program, both Medicare and Medicaid, so that there would be adequate beds, and people had placements, and the emphasis has really never been on improving quality of care, or on achieving compliance.

The current system as designed by the Federal law essentially has only one operational sanction, and that is to decertify a facility from participation in Medicaid and Medicare. As we heard, less than 1 percent of facilities are decertified every year, and you can imagine why.

That is a very serious sanction. In many States, there are difficulties in transferring people, placing them into other settings, so

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it is a sanction that doesn't have any real regulatory meaning, because it is not—because it is too severe in some cases, and not likely to be used by enforcement personnel, because they recognize the practical problems that it will present.

Congress in 1981 enacted an additional sanction which would have allowed States to suspend the admission of new Medicaid residents, and also allowed HCFA to suspend admission of new Medicare residents into a facility that had some deficiencies which would have an immediate and increasing impact on the facility's revenue, cash-flow.

That important authority, however, has never been adopted into a permanent regulation, and therefore, States are not in a position to use it under their Medicaid programs.

One of the very important recommendations in the enforcement area that the committee has made is to require at the Federal level that every State have a certain core set of what we have called intermediate sanction authority.

As Mr. Pepper mentioned, civil fines, and we have talked about suspension of admissions, which is in the statute, but not in a way that the States can take advantage of it, and also other kinds of authorities like receiverships for special cases, and the concept of an intermediate sanction is that the enforcement system needs to have tools that are credible that can in fact be used, and that can be tailored to the severity of a particular problem.

Many of the problems that we saw through our hearings and our case studies should not necessarily result in a termination of a facility's participation in Medicaid, but they do need to be remedies, addressed so an intermediate sanction can be tailored to the severity of a problem and enforced and applied quickly.

That is another problem with the suspension of the admissions law that Congress enacted in 1981. That statute required a formal hearing before that admissions suspension can take effect, which is much more than the courts have required under due process, and although that system hasn't gone into effect when it finally does, that will delay the effectiveness of that type of a sanction.

These sorts of sanctions like civil fines need to be able to be enforced swiftly because if an enforcement agency doesn't think it has real enforcement powers, because they are a sham, it will not take aggressive enforcement action, and nursing homes that are inclined not to conform to standards are going to be less likely to believe that a sanction will be applied against them, and a vicious cycle begins to happen, so a certain proportion of the facilities tend to go in and out of compliance, and are sort of on the hairy edge of being in compliance with the standards, and the enforcement system is not assigned to address that problem.

Mr. WALGREN. Mr. Chairman, if I might ask you whether you have the same fear that I think I have about a change, a comprehensive change here, during which States might substantially downgrade the effort that they put into nursing home care.

In Pennsylvania, for example, in 19—I guess between 1980, 1983 or so, we reclassified something like 70 percent of our skilled nursing home beds to intermediate care. The fundamental reason for that was that the State didn't want to spend the money, even

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though the Federal Government was picking up somewhere in the range of 50 percent of every dollar spent.

The State budget was so tight, and the rate of increase of medical demand in an aging population was so real that our government chose to reduce its investment in medical care, and the interesting thing, when you talk about the thought of really wiping out this difference between intermediate care and skilled nursing home care, in a sense, Pennsylvania had gone forward and established a rather all-encompassing level of care.

It was technically called skilled care, but when they wanted to reduce their tax investment, they then chose the technicality of reclassifying it and reducing the effort, the State effort.

Now, what I fear is that if we have now a major change in the system, at a time when States have tremendous incentives to reduce their effort, what is to maintain the effort that is going into providing care for nursing home populations?

Ms. BUTLER. One technical response that you should be aware of is that the combination of skilled and intermediate care facilities that the committee recommends would require that facilities meet the current skilled nursing facilities standards, which is the higher set of standards, so States wouldn't have the option of reducing the level of compliance in the way that Pennsylvania may have attempted to do.

The political issue you raise is a very important one.

Dr. KATZ. I would like Dana to speak to this, please.

Ms. PETROWSKY. Well, you get at a very basic issue, and that is the States' willingness to go along with the Federal Government's standards, and their willingness to support the cost of high-quality care.

Perhaps a good analogy would be the difference between the quality of care you see in the Nation's certified nursing homes and what you see at the board and care level where there is no Federal inspection program, and there are no Federal standards.

The committee's amendment tried to get at this by telling the Federal Government to establish standards, but there are no minimums, and so you are to a degree circumscribed in your attempts by the willingness of the States to go along with your goals.

Mr. WAXMAN. The committee is recommending the elimination of the regulatory distinction between skilled nursing facilities and intermediate nursing facilities. The distinction between the two is the different level of care that each provides.

In Iowa, nearly all of the nursing homes are certified as ICF's. Under the committee's recommendation, Iowa's nursing homes would have to meet a higher standard to be certified for participation in the Medicare and Medicaid programs.

What has been Iowa's response to this recommendation? How have other States responded? Do States want to differentiate in any way between the class of facilities that provide more and less incentive care? How do the States envision their facilities responding to the needs of heavy care patients. And should all facilities be required to meet those standards?

Ms. PETROWSKY. The committee has recommended, when you look at the 50 States, there is no rational reason why some States have 99 percent ICF beds and others have 99 percent skilled beds.

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We can't believe that the populations are that different. The significant difference between an ICF and the skilled facility is the staffing.

There will have to be 24-hour nursing care which would be required in a skilled facility, is not required in an ICF. I don't know that my State or any other State has come out with a position in that regard.

Mr. WAXMAN. Ms. Brown and Mr. May, you are representatives of owners and operators of nursing home facilities. Do you agree we should abolish these distinctions?

Ms. BROWN. Yes, sir, I do. One of the reasons why is what happened in Pennsylvania, as far as reclassification, and today, maybe they might be skilled patients and tomorrow they would be ICF, and there is a reduction in the reimbursement rate.

They are the same residents and have the same needs. As we recommended in the report, we also talked about the case mix reimbursement, really looking at the needs of the facility based on resident needs in that facility, and gearing more toward that type of system.

Mr. WAXMAN. Mr. May.

Mr. MAY. The development of the ICF's and SNF's is a development to save money. To reduce the level of care. The distinction has been blurred. In different parts of the country, they are called different things, so I truly believe there is a change, and the future populations going to nursing home care will be much heavier kinds of care patients, with the home care program being developed for the elderly.

Mr. WAXMAN. Thank you very much.

When our subcommittees entered into an agreement with the HCFA 3 years ago to undertake this study just completed, we made it clear that we wanted a report that would make solid recommendations, that would be useful, and not just sit on the shelf.

HCFA agreed, and in reviewing the report, it is fair to say that both of us got what we asked for. You made solid recommendations, and your report is useful, and it isn't just sitting on the shelf. In fact, discussion and debate about the report are already well underway.

I suspect, however, that many Members of Congress and representatives of the administration will say that your recommendations go too far and that these cost too much.

My question to you then, any one of the panel, is simply this: How difficult will it be to implement your recommendations, and can't many of them be put into effect at little or no cost?

Dr. KATZ. I will make a few general statements and then answer. I emphasize again that this is a three-legged stool, and the problems in the past have been that it has been tinkered with; and I wouldn't like to see us put a lot of energy into continuing the tinkering.

We have to start working on all parts, and any—and concern for cost of starting and implementing, we would prefer that that be seen as how deeply we go into any area than whether we go into an area or not.

It is possible at every level to start something now at reasonable cost or minimal cost. There are some flexibilities within HCFA to

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do things differently now, the very effort to implement PaCS and the training effort related to it illustrates that change can be done within the system, and is being considered.

There are offsets, two examples of cost issues. We talked about a short and a long survey, which would result in some savings. There is a cost change, I believe, so that there is some cost involved. It could be started.

An important viewpoint that we have expressed is the idea that there be some oversight, congressionally delegated to see things went along in a timely way, that they were addressing the system, and that cost effectiveness was being monitored.

I would like to ask some of the committee members in response to indicate what are some of the things that could be done now in areas that they have a lot of experience with.

I have had a chance to say something about the information system.

Ms. FREEMAN. Mr. Chairman, to carry this a step further, yes indeed, it is an emphatic report, but it is also the least we ought to expect.

A term of art, it is bottom line, the compromise document. It could have been costed out higher, I should think. The committee took great pains not to divide its recommendations into the important ones and the unimportant ones, expensive and inexpensive ones, the acceptable ones and the marginal ones.

These are, as Dr. Katz has described them, three coordinated parts of an improved system. There are some things that need to be done right away, changes in law that would enable the HCFA to take up some of what is recipe in the report, and some of what is literal expression of a new standard or condition, and get on with that work.

The experience I have had at State level regulation of nursing homes is that the passage of the law is a reasonably efficient thing to do.

The gestation period for rulemaking is significantly longer, so what we are looking at here is an opportunity to get the ball rolling through the passage of laws, but then looking toward a process by which you as public officials, and we in the community as providers and regulators and consumers watch over the process within the Health Care Financing Administration to say, let there be specific assignments to do parts of these recommendations right away, and let those be scheduled, and know who is about to do what.

Let there be some coordination between and among the different divisions of the HCFA, and those who write the rules and those who budget for the rules and those who work with legislation.

We are going to need to take from the report we have now some accountability for what happens next internally within the Department and externally as each of us continues to advise on the process.

Having said all of that, there are indeed within those recommendations that have been of particular concern to consumer organizations some things that could be done right away, and could indeed be characterized as little or no cost changes.

The recommendation that each facility be able to demonstrate a method by which the views, the satisfaction or the dissatisfaction of

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residents and families are incorporated into the decisionmaking of that facility, and that could happen right away.

The process by which facilities would be expected to notify relatives or guardians when there is a change in health status, a change in the billing, involving people from the outside, that can happen right away.

It doesn't take much time or money to pick up a phone, that can happen. Allowing access by community volunteers, that wouldn't take any time and money.

There are things that can happen quite soon.

Mr. WAXMAN. Mr. May.

Mr. MAY. I guess I am not sure I am going to say what you want to hear, but I really tend to believe that the costs of the nursing home system today and the prices we are paying for it, the gross national product, is probably inadequate to provide the kinds of care the public really wants, and this is a personal feeling.

To implement the system, it might not cost that much, but I personally believe that, unless we get a system like this moving, we are not going to be ready for the next 10, 20 years when we have a lot more elderly people, and unless we want it for ourselves or our parents or our children, I don't think we really can sit still, and I think we have to move on this, and if we can figure out a way to move it without it costing too much, that is one thing.

I just don't believe you can really move on a system or make a major change like this without it costing something. I am not sure how much, though.

Mr. WAXMAN. Ms. Brown, I am very pleased to note that the nursing home industry has been involved in this report and part of the formulation of the recommendations. How do you see the cost of these recommendations affecting you? Do you support the kind of recommendations that have been made and the implementation of those recommendations?

Ms. BROWN. It has been an interesting 2 years to work on this committee, and we have all learned a lot from each other and how one another think, and I think we are all pleased that at the end of that 2 years, we have been able to come out with a report and with the consensus we have developed through the 2 years of work and study; and yes, I am very much in support of the report.

I think it is going to have a cost impact in some areas, and as I said earlier, we did talk about that, and felt that our task was to look at the regulatory system in the past, and the future, and the individuals in our long-term care facilities, and come up with a set of recommendations that we felt was in their best interests and could impact long-term care and that is what we did, and we felt we should hesitate to do things strictly from a cost standpoint.

And we tried to put that aside. I am concerned about the cost, and it is time that our society made a commitment to the care of our elderly and that is going to have to come to do some of these things.

We need to recognize the fact that this is not something we put off to the future, and has to be implemented in its entirety in the future. The foundation in many of these areas has already been laid, but not on a national basis, and while there is a lot in here on

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patient's rights, some of that is already being upheld in some parts of the country, but not all across the countries.

PaCS, while the report did not support PaCS in total it is certainly headed in the right direction, and that kind of activity needs to continue.

That is going on already. There are already some things going on as far as terminations and maybe Pat could better speak to what needs to be done to further that.

The foundation has been laid in many of the areas, to pick up and proceed in to strengthen and enhance quality of care for our elderly.

Mr. WAXMAN. Thank you very much.

Dr. Katz.

Dr. KATZ. I wanted to give Pat and Dana a chance, with your permission.

Mr. WAXMAN. Sure.

Ms. BUTLER. The whole area of enforcement and the survey process we talked about a little earlier, although the two-stage survey process we are discussing is something that could not be put into place tomorrow, the PaCS instrument as an example, is very much in tune with the direction that the committee was suggesting the survey system ought to be moving, and could relatively easily be refined to incorporate the committee's suggestions, and could then form the basis of that two-stage survey system, which would have the effect of targeting the limited resources on facilities where poorer care is being provided, and at the same time, rewarding good facilities by lessening their burdens of survey and paperwork.

So, we think that the cost of that particular system, once it is up and running, is as likely not to be an increase over the current system, but simply a more efficient and effective way of targeting what we all recognize are some scarce resources.

Ms. PETROWSKY. In regard to the role relationship between the Federal and State government, there are certain things the committee recommends that could be implemented rather quickly that might not have significant cost impact, and that is, we are recommending there be an increased look behind of the Federal Government to what the States are doing.

We need to free up some time in the Federal regional offices, that they could perform these look behind inspections, and also recommending inspections be combined with survey, combining those two programs and allow more resources to go into the inspection function that the States perform.

The two-stage survey process will lighten the load on the good providers and allow the survey agencies to spend increased time in the problem facilities.

The annual survey cycle should be flexible to run 9 to 15 months to increase the element of surprise when an inspection would be conducted to a 6-month period and therefore, facilitate the intention of an unannounced inspection.

Mr. WAXMAN. Well, thank you very much, Dr. Katz and members of the panel. You have our gratitude and commendation for the report you prepared for us, and we look forward to working with you in seeing that it is implemented.

Dr. KATZ. We all thank you.

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Mr. WAXMAN. That concludes our business for today. Our subcommittees jointly stand adjourned.

[Whereupon, at 12 noon, the subcommittees were adjourned.]

[The following materials were submitted for the record:]

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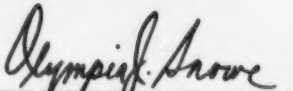

OLYMPIA J. SNOWE

March 25, 1986

STATEMENT FOR THE JOINT HEARING OF THE
THE COMMITTEE ON ENERGY AND COMMERCE,
THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT AND
THE SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

Mr. Chairman and Members of the Subcommittees. I want to compliment you for holding this important hearing on the Institute of Medicine's (IOM) recommendations on nursing home regulations. You are to be commended for your continuing concern and involvement in issues that relate to health and long-term care for our older citizens.

I was pleased to see that this report has finally been released after more than two years of work and study by the IOM Committee. We all have been concerned with the issue of quality of care and quality of life in nursing homes. This report underlines the need to protect those who are most dependent in our society, the individuals who reside in nursing homes. The findings are illuminating because the principal message is that regulation is essential. While many of us believe that it is necessary to have less government regulation where appropriate, it is clear that within nursing homes this is not necessarily in the best interests of the residents.

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For this reason, early in February I introduced H.R. 4279, the Long-Term Care Residents' Bill of Rights. While some regulations purport to protect the institutionalized, there is currently no existing statute that specifically guarantees the civil rights of long-term care residents. As a consequence, my bill would insure that nursing home residents have the right to sue the facility in which they live for violations of their rights. In addition, H.R. 4279 would prohibit discrimination against patients who are Medicaid recipients, would require that residents be informed about their medical condition and the treatment, would assert the rights of residents to freedom from physical and mental abuse, and would assure the right of residents to privacy, confidentiality, and freedom of association.

Further, my bill would stengthen the role of the Ombudsman program by establishing their legal right to access to facilities and residents in nursing homes and establish civil, administrative and criminal procedures for complaint resolution. Eligibility for receipt of Medicaid would be contingent upon the State's development of a plan that would detail the way in which these and other provisions would be assured in all long-term care facilities in which older persons reside.

There is little surprise that my bill closely parallels key provisions of the IOM study. In conversations with groups that advocate on behalf of the elderly, concerns about nursing home patients surfaced time and again, particularly as they relate to regulatory criteria, monitoring performance, enforcement and quality of care issues. The IOM study has faithfully captured those elements essential to improving our long-term care system.

Again, I am pleased that Mr. Pepper and Mr. Waxman have called this hearing on this topic of mutual concern.

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1424 16th St. N.W.
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News

REFERENCE:
Congressional Hearing
Re: Institute of
Medicine Report
Tuesday, March 25, 1986
2123 Rayburn HOB

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CONSUMER ADVOCACY GROUP APPLAUDS IoM REPORT

The National Citizens' Coalition for Nursing Home Reform has hailed the Institute of Medicine report, Improving the Quality of Care in Nursing Homes, for providing "timely, thoroughly researched and critically needed support for improving federal regulatory protections for nursing home residents."

"Over the past few years, there has been a strong push within the federal government to deregulate not only business but also human services," said NCCNHR Executive Director Elma L. Holder. "The IoM report--which is the direct result of the Reagan Administration's attempt to cut back on federal and state oversight of nursing homes--says very strongly that deregulation is inappropriate for nursing homes.

"It also supports a number of specific reforms the Coalition and its members have been calling for the past decade."

The National Citizens' Coalition for Nursing Home Reform was founded in 1975 during a period of intense criticism of the nursing home industry because of poor care and abuse of residents. Individual members and 260 state and local member organizations work through the Coalition to promote improvement of federal and state policies affecting nursing home residents.

In 1933, NCCNHR published a Consumer Statement of Principles on nursing home regulations, endorsed by 40 national organizations, that articulated many of the reforms called for in the IoM study.

Holder said several recommendations of the Institute of Medicine are particularly high on the Coalition's agenda for nursing home reform:

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- Mandatory preservice training for nurses' aides.
- Resident participation in decisions about their care and the operation of the nursing home.
- Resident participation in nursing home inspections and reports of surveyor's findings.
- Prohibition against Medicaid discrimination.
- Financial support and legal reinforcement for long-term care ombudsman programs.
- New emphasis on quality of life, residents' rights and quality of care for each individual.
- Broadening of sanctions to penalize facilities that provide bad care.
- Strengthened federal financial support and leadership in the administration of the regulatory and enforcement system.

Holder praised IoM for recommending state-certified training for nurses' aides, but she said other employee reforms not mentioned by IoM also are critically needed. A 1984 NCCNHR survey of more than 400 nursing home residents (published as A Consumer Perspective on Quality Care: The Residents' Point of View) found that residents viewed workers as the most important component of quality care.

"Nurses' aides provide most of the direct care received by nursing home residents," said Holder, "yet most of them have little or no training, and they make minimum wage. We're pleased IoM called for increasing training for aides, but we believe other steps should be taken as well to improve the morale and professional status of nursing home workers."

Holder said these include increased wages and benefits, better supervision, and better supplies and equipment with which to work.

The federal reimbursement system (under Medicare and Medicaid) was not within the scope of IoM's study. Noting that half the money supporting nursing homes in the United States comes from federal programs, Elma Holder said there is a vital need for the government to undertake a comprehensive study of reimbursement.

"Nursing homes complain that federal reimbursement is too low," Holder said, "and they use that as an excuse to limit Medicaid

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enrollments and curtail services to Medicaid residents. Yet we know that large nursing home chains return very large profits to their stockholders, and that part of those profits are coming out of taxpayers' funds.

"At a time when we're talking about cutting back on Medicare and Medicaid, there is a critical need to examine what taxpayers and nursing home residents are getting for their tax dollars."

Although IoM did not study reimbursement, it did conclude that the reimbursement rate in itself does not dictate good or bad care. A study conducted for the IoM committee found that the quality of care varied greatly among homes with a similar percentage of Medicaid beneficiaries and similar rates.

Holder noted that the Health Care Financing Administration is currently implementing a new long-term care survey system that requires surveyors to interview nursing home residents and to conduct a thorough review of a selected sample of residents in order to determine the quality of the care they receive. While these changes in the federal/state survey system are important, she said, they address only a small number of the reforms cited by IoM.

The National Citizens' Coalition for Nursing Home Reform has called upon all those concerned about quality care for nursing home residents to join together in a thoughtful and thorough effort to implement IoM's recommendations. Holder has recommended that a task force of federal agencies be convened to assure coordination of effort and to solicit advice from consumers, providers, regulators, nursing home professionals and IoM study committee members.

"Quick fix responses to IoM's recommendations would be a disservice to the hard work and great investment the study represents," Holder said. "We now need concerted public support to move Congress and the Department of Health and Human Resources to implement the reforms IoM has called for."

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Improving the Quality of Care in Nursing Homes

INSTITUTE OF MEDICINE

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1

Introduction and Summary

PURPOSE OF THE STUDY

This is the report of a study of government regulation of nursing homes (excluding intermediate care facilities for the mentally retarded). The study's purpose was to recommend changes in regulatory policies and procedures to enhance the ability of the regulatory system to assure that nursing home residents receive satisfactory care.

In May 1982, the Health Care Financing Administration (HCFA) announced a proposal to change some of the regulations governing the process of certifying the eligibility of nursing homes to receive payment under the Medicare and Medicaid programs. The changes were responsive to providers' complaints about the unreasonable rigidity of some of the requirements. The proposed changes would have eased the annual inspection and certification requirements for facilities with a good record of compliance, and would have authorized states, if they so wished, to accept accreditation of nursing homes by the Joint Commission on Accreditation of Hospitals (JCAH) in lieu of state inspection as a basis for certifying that Skilled Nursing Facilities (SNFs) and Intermediate Care Facilities (ICFs) are in compliance with

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the federal conditions of participation and operating standards.

The HCFA proposal was strongly opposed by consumer groups and most state regulatory agencies because the proposed changes were seen as a movement in the wrong direction--that is, towards easing the stringency of nursing home regulation--and because they did not deal with the fundamental weaknesses of the regulatory system. The controversy generated by the proposal caused Congress in the fall of 1982 to order the HCFA to defer implementing the proposed changes until August 1983 and ultimately resulted in a HCFA request to the Institute of Medicine (IOM) of the National Academy of Sciences to undertake this study. The contract between the HCFA and the IOM became effective on October 1, 1983. The charge to the IOM Committee on Nursing Home Regulation was to undertake a study that would "serve as a basis for adjusting federal (and state) policies and regulations governing the certification of nursing homes so as to make those policies and regulations as appropriate and effective as possible."[1]

THE PUBLIC POLICY CONTEXT OF THE STUDY

There is broad consensus that government regulation of nursing homes, as it now functions, is not satisfactory because it allows too many marginal or substandard nursing homes to continue in operation. The implicit goal of the regulatory system is to ensure that any person requiring nursing home care be able to enter any certified nursing home and receive appropriate care, be treated with courtesy, and enjoy continued civil and legal rights. This happens in many nursing homes in all parts of the country. But in many other government-certified nursing homes, individuals who are admitted receive very inadequate--sometimes shockingly deficient--care that is likely to hasten the deterioration of their physical, mental, and emotional health. They also are likely to have their rights ignored or violated, and may even be

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subject to physical abuse. The apparent inability of the current regulatory system either to force substandard facilities to improve their performance or to eliminate them is the underlying circumstance that prompted this study.

In the past 15 years many studies of nursing home care have identified both grossly inadequate care and abuse of residents.[2-23] Most of the studies revealing substantial evidence of appallingly bad care in most parts of the country have dealt with conditions during the 1970s. However, testimony in public meetings conducted by the committee in September 1984, news reports published during the past 2 years, recent state studies of nursing homes, and committee-conducted case studies of selected state programs have established that the problems identified earlier continue to exist in some facilities: neglect and abuse leading to premature death, permanent injury, increased disability, and unnecessary fear and suffering on the part of residents. Although the incidence of neglect and abuse is difficult to quantify, the collective judgment of informed observers, including members of the committee and of resident advocacy organizations, is that these disturbing practices now occur less frequently.

Residents and resident advocates, both in public hearings and in a study of resident attitudes conducted by the National Citizens' Coalition for Nursing Home Reform,[24] expressed particular concern about the poor quality of life in many nursing homes. Residents are often treated with disrespect; they are frequently denied any choices of food, of roommates, of the time they rise and go to sleep, of their activities, of the clothes they wear, and of when and where they may visit with family and friends. These problems may seem at first to be less urgent than outright neglect, but when considered in the context of a permanent and final living situation they are equally unacceptable.

The quality of medical and nursing care in many homes also leaves much to be desired. Geriatrics is becoming, in the mid-1980s, an area of concentration within internal

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medicine, family medicine, and psychiatry. (Both the American Academy of Family Practice and the Board of Internal Medicine have decided to establish certificates recognizing geriatric competence.) Many conditions that were once accepted as inevitable consequences of old age now can be treated or alleviated. Physicians and nurses in nursing homes are not always aware of advances in geriatrics so that even in pleasant and humane institutions examples may be found of residents whose disability could be reduced, whose pain could be controlled, or whose depression could be treated if they received proper medical care. A lower standard of medical and nursing practice should not be accepted for nursing home residents than is accepted for the elderly in the community. Given the fragility of nursing home residents and their dependence on medical care for a satisfactory life, practice standards should even be higher. Thus, physicians, as well as nurses, have substantial responsibility for quality of care in nursing homes.

These observations do not mean that the picture of American nursing homes is entirely gloomy or that the regulatory efforts of the past decade have been entirely unsuccessful. Today, many institutions consistently deliver excellent care. Good care can be observed in all parts of the country; it exists under widely varying reimbursement systems and all types of ownership. Such facilities serve both as evidence that overall performance can be improved and as markers for how that improvement can be accomplished.

The question asked by the committee was: How can the problems observed in nursing homes in the 1980s best be addressed? The current national tone is antiregulatory. Nursing homes are a service industry. Could not the observed problems be solved by decreasing regulation and allowing market forces to work? This viewpoint was advocated by some who spoke at public meetings or submitted ideas to the committee. Those who wished to see a freer market were particularly anxious to have restrictions on bed supply lifted.

A freer market was not considered by the committee to be a serious alternative to more effective government regulation for two reasons.

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First, under present circumstances, a free market for nursing home care will remain a theoretical concept until such time, if ever, that a major portion of the financing of long-term care services has shifted from public sources (primarily Medicaid) to private insurance. This is not likely to occur very soon. About half of current nursing home revenues come from appropriated state and federal funds through state-controlled Medicaid programs. Most people enter nursing homes as private-pay residents and soon "spend down" their income and assets until they become eligible for Medicaid. With few exceptions, community-based or home-based long-term care services--that might keep some people who require long-term care from entering nursing homes--are not eligible for Medicaid or other sources of public support. Most states maintain tight control on bed supply to control growth of their Medicaid budgets. They have learned that if they allow uncontrolled growth of nursing home beds, the additional beds would quickly be filled with residents now being cared for privately and informally in the community. Such residents would initially be private-pay, but would soon "spend down" to Medicaid eligibility.

Second, historical experience hardly supports an optimistic judgment about the effects on quality of care of allowing market forces, to exert the primary influence over nursing home behavior. Nursing homes were essentially unregulated in most states prior to the late 1960s. Their operations were governed almost entirely by market forces, and the quality of care was appalling. (See Appendix A.)

Persons needing nursing home care generally suffer from a large array of physical, functional, and mental disabilities. A significant proportion of all residents are mentally impaired. The average resident's ability to chose rationally among providers and to switch from one provider to another is therefore very limited even if bed occupancy rates are low enough to make such choices feasible. But they are not. In most communities, bed availability is the controlling factor because occupancy rates are very high. Moreover, some who reside in nursing homes lack close family to act as their advocates. Even

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if they have family, the choice of a nursing home is usually made relatively hastily in response to a new illness or disability level; once in an institution, the opportunities for transfer to another nursing home are very limited.[25]

The difficulties inherent in choosing among nursing homes are further exacerbated by the financial status of many residents. Because of the cost, few individuals or families can afford a prolonged nursing home stay.[26] As a result, government programs, primarily Medicaid, assist in paying for more than 60 percent of all care. In most states, Medicaid rates are lower than those paid by private residents. As a result the nursing home market is in fact two markets--a preferential one for those who can pay their way and a second, more restricted one, for those whose stays are paid by Medicaid.[27]

Regulation is essential to protect these vulnerable consumers. Although regulation alone is not sufficient to achieve high-quality care, easing or relaxing regulation is inappropriate under current circumstances.

The federal regulations now governing the certification of nursing homes under the Medicare and Medicaid programs have been in place, essentially unchanged, since the mid-1970s. Their central purpose is to assure that nursing home residents[28] receive adequate care in a safe facility and that they are not deprived of their civil rights. The regulations have a number of conceptual and technical weaknesses that were recognized almost from the time the regulations were promulgated. And, the regulations are administered and enforced very unevenly by the states. Yet there is consensus that regulations have made a positive contribution, although reliable comparative data are not available to support this judgment. The committee found that the consumer advocates, providers, and state regulators with whom it discussed these matters believe that a larger proportion of the nursing homes today are safer and cleaner, and the quality of care, on the average, probably is better than was the case prior to 1974. But there is substantial room for improvement.

Providers, consumer advocates, and government regulators all are dissatisfied with specific aspects of the

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regulations and the way they are administered.[29] Consumer advocates (nursing home residents, their families, and representatives of organizations concerned with protecting the interests of nursing home residents) contend that the standards are inadequate and their enforcement is too lax because too many nursing homes that pass inspection still provide unacceptably poor or only marginally adequate care. Moreover, they contend that violations of residents' rights occur in many homes and that often such violations either are not detected or are ignored by the regulatory authorities. The providers (nursing home operators, administrators, and professional staff) are concerned with the excessive attention to detailed documentation, the emphasis on structural specificity with the inherent (and sometimes irrational and costly) inflexibility that such specificity implies, and with the ambiguity of some of the standards (for example, the use of such words as "adequate") that result in inconsistent, subjective interpretations by state and federal surveyors. Some government regulators at both state and federal levels believe there is merit in both sets of contentions.

Since the present regulatory framework was set in place about 10 years ago, there have been developments that make possible a more effective regulatory system. There is deeper understanding of what is meant by high-quality care for nursing home residents and how to provide it, more knowledge of how to assess quality of care objectively, and better understanding of what it takes to operate a more effective quality assurance system. The nursing home industry itself has grown in managerial capability and professionalism. These developments make it possible now to redesign the regulatory system so that it will be much more likely to assure that all nursing homes provide care of acceptable quality.

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8 / *NURSING HOME CARE*

PERSPECTIVE ON THE ISSUES

The Role of Nursing Homes

In most places in this country, when an elderly (or disabled younger*) person requires more assistance in the activities of daily living[30] than can be provided by immediate family or friends, and especially if the individual is incontinent and/or mentally impaired, he or she may be placed in a nursing home. Also, when an elderly patient, after surgery or an acute medical episode in a hospital, requires rehabilitative/convalescent nursing care for several weeks or months, and neither a rehabilitation hospital bed nor home health services are available in the community, the patient may be discharged to a nursing home. Home health services, congregate housing, domiciliary care, day-care centers, and other professionally organized arrangements exist in some communities and provide long-term care services to elderly persons with disabilities comparable to those found among some residents in nursing homes. Although more of these types of long-term care arrangements are being developed, they still represent collectively only a small fraction of the total person-days of care provided by nursing homes.[31] In 1985, in most communities in this country, long-term care services for the physically frail and mentally impaired elderly are available only through informal support provided by family or friends or in nursing homes.

Nursing homes must provide care to a very heterogeneous resident population. Some require short-term, intense rehabilitation services. Many others are incontinent, mentally impaired, or so seriously disabled that they require extensive and continuous care for months or years. A small fraction are younger people who are severely disabled. A few are simply very old and very

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*In 1985, 13 percent of nursing home residents were under 65 years of age. This figure is projected to drop to 9 percent by the year 2000. See Appendix D, Table D.1.

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frail but are mentally competent and alert and require only moderate assistance in the activities of daily living and opportunities to participate in activities to satisfy their psychosocial needs.

It is not easy to provide high-quality care to meet such a broad spectrum of physical, medical, and psychosocial needs in one facility. Not all nursing homes admit all of these types of residents, but many do. If, in the future, alternate arrangements become available to provide proper care to some individuals requiring intensive short-term rehabilitation services (for example, stroke patients), and for those requiring on a long-term basis only moderate amounts of support services, nursing homes will not be expected to accommodate these kinds of residents. Nursing home beds are increasingly being filled with long-term, very disabled residents who cannot be cared for anywhere else. Pressures to admit a higher proportion of residents requiring "heavy care" (nursing home jargon referring to residents requiring at least 2-1/2 hours per day of personal and nursing care), many of whom are mentally impaired, has been experienced by nursing homes for some time. These pressures are certain to increase.[32]

There were about 15,000 nursing homes in operation in the United States in 1985, with a total of about 1.5 million beds, that are certified to receive patients/residents under the Medicare and/or Medicaid programs.[33] About 1,000 nursing homes and perhaps 6,000-7,000 "board and care" homes (sometimes referred to as "domiciliary care" facilities) without nursing services are licensed by the states but are not certified to accept Medicare or Medicaid payments.[34]

There are two types of nursing homes recognized in federal regulations: Skilled Nursing Facilities (SNFs) and Intermediate Care Facilities (ICFs). SNFs are required to be staffed and equipped to care for residents requiring skilled nursing care. ICFs are required to be staffed and equipped to care for residents requiring less nursing care and more personal service care. In practice, the states are not consistent in making distinctions between the two types of nursing homes: some states have almost no SNFs; others have almost no ICFs. Forty-three percent of all nursing homes are ICFs (Appendix D, Table

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C). The mix of characteristics and service needs of the residents found in SNFs in those states that have few ICFs do not appear to differ significantly from those found in ICFs in states that have few SNFs.

About 70 percent of the certified nursing homes, with 80 percent of the beds, are operated on a for-profit basis. Of the rest, 22 percent of the facilities are operated by nonprofit organizations and the other 8 percent are government-owned and -operated.[35] In almost every state, occupancy rates average well over 90 percent, an indication that the demand for nursing home beds is very high.[36] Demographic trends--the rapidly growing numbers of persons over 75 years old, about 1 in 10 of whom are now in nursing homes--make it certain that the demand for nursing home beds will continue to grow. A recent report projected the population aged 75 and over in the year 2000 to be 17.3 million, a 46 percent increase over the 1985 population of that age group. For people 85 years of age or older, one in five of whom is currently in a nursing home, the numbers are projected to increase from 2.85 million in 1985 to 5.1 million in 2000, an 80 percent increase.[37] In 1984, over $30 billion was spent on nursing home care.[38] According to Department of Labor estimates, "nursing and personal care" facilities employed over 1 million people in 1982.[39]

Quality of Care and Quality of Life

Providing consistently high quality care in nursing homes to a varied group of frail, very old residents, many of whom have mental impairments as well as physical disabilities, requires that the functional, medical, social, and psychological needs of residents be individually determined and met by careful assessment and care planning--steps that require professional skill and judgment. This process must be repeated periodically and the care plans adjusted appropriately. Not all nursing homes have enough professional staff who are trained and motivated to carry out these tasks competently, consistently, and periodically. Care is expensive because it is staff-intensive. To hold down costs, most of the

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care is provided by nurse's aides who, in many nursing homes, are paid very little, receive relatively little training, are inadequately supervised, and are required to care for more residents than they can serve properly. Not surprisingly, the turnover rate of nurse's aides is usually very high--from 70 percent to over 100 percent per year--a factor that causes stress in resident-staff interactions.

Quality of life is intimately related to the quality of resident-staff relationships. Kindness, courtesy, and opportunities to choose activities, food, and mealtimes are involved, as are factors such as privacy for intimate conversations with family or friends. This is difficult when most rooms are semiprivate--as is the case in most nursing homes. Making one's room as home-like as possible is important to many residents, but fire safety codes may limit the use of personal furniture or other belongings. And, it may not be possible to choose or change one's roommate.

Difficult as these problems may be, they can be handled satisfactorily by competent management and staff. In most regions of the country, very good homes can be found--places that are well-managed, where competent, caring staff provide services in a conscientious, sensitive manner; where the dignity, privacy, and human needs of the residents are respected and provided for in thoughtful, even imaginative ways. There are both for-profit and not-for-profit homes in this group. The exact number of very good homes is unknown because no objective, reliable methods exist for making interfacility comparisons of quality. The committee has the impression, obtained primarily from the Health Care Financing Administration's data collected from state reports on nursing home deficiencies, and from discussions with knowledgeable state and federal regulatory agency personnel, that the poor-quality homes outnumber the very good homes.

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The Regulatory System

Government regulation of nursing homes has two broad goals: (1) consumer protection, that is, to ensure the safety of residents, the adequacy of care they receive, and that their legal rights are protected; and (2) to control and account for the large public expenditures--mainly Medicaid--used to pay for nursing home care.

Regulation for quality assurance in nursing homes involves three main components, all of which are more or less embodied in both federal and state regulations and are, to some extent, intertwined with one another. They include

1. developing and promulgating explicit criteria (conditions of participation and standards) governing all aspects of the operation of nursing homes;
2. developing and applying standard procedures and criteria for monitoring the performance of nursing homes and for determining the extent to which nursing homes are complying with the performance criteria (monitoring procedures include periodic surveys of nursing homes, inspections of care, and investigations of complaints of poor care, neglect, or abuse of residents); and
3. enforcing compliance with the performance criteria in cases where unsatisfactory performance is found.

Both the federal and state governments are actively involved in regulating nursing homes, but the states' role is much larger. There is no American nursing home regulatory system; there are regulatory systems in 50 states and the District of Columbia with substantial differences in such things as organizational arrangements, resources committed to the licensure and certification process, the size and composition of the survey teams and the amount of time they spend inspecting nursing homes, the extent and nature of the training provided to surveyors, and in organizational ethos, that is, whether the agency is "enforcement-oriented" or "compliance-oriented." (This issue is discussed in Chapter 4.)

The federal government prescribes detailed standards that must be met by certified nursing homes, but it is the

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states that inspect (survey) the nursing homes to determine the extent of compliance with the certification standards. Although the federal government has the authority to "look behind" the states' survey and certification activities, it has never allocated much staff to this function. It conducts look-behind actions in about 3 percent of the facilities annually.

The states license nursing homes, but their licensure standards vary widely. About one-quarter have made them identical to the federal certification standards. About one-quarter have licensure standards that are less stringent than the federal certification standards. About half have more stringent licensure standards. (Appendix C contains a report of a survey of state licensure and certification agencies, conducted by the committee during 1984-1985, from which these data were obtained.)

The states also are responsible for enforcing the standards. The only federal sanction available, until recently, was decertification of a facility--that is, to make the facility ineligible to receive Medicaid or Medicare funds. In 1981 a federal intermediate sanction--suspension of payments for new admissions--was authorized by law. But regulations specifying how this authority should be used had not been issued as of February 1986. Since decertification is a very drastic measure when beds are in short supply, it is seldom invoked. Most states rely on a set of "intermediate" sanctions (fines, suspension of admissions, receiverships) available under their licensure authorities. But availability and use of intermediate sanctioning authority vary widely with states, as do enforcement attitudes and actions. Tolerance of inadequate care also appears to be widespread.

The history of nursing home regulation is relatively brief. Until the passage of the Medicare and Medicaid legislation in 1965, the regulation of nursing homes was entirely a state responsibility. (The history of the development of the federal role in nursing home regulation is summarized in Appendix A.) By 1965, there were hundreds of thousands of residents in nursing homes that did not meet Hill-Burton fire and health standards and were substandard in other respects as well--for example,

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with poorly trained or untrained staff and few of the necessary services.

The problems were described extensively by the U.S. Senate Special Committee on Aging that conducted several sets of hearings starting in 1963. (See Appendix A.) The initial efforts to set federal standards for both Medicare "extended care facilities" (ECFs) and for Medicaid SNFs quickly exposed the problems. Of 6,000 facilities that applied for certification as ECFs, only 740 could be certified the first year. More than 3,000 others were certified as being in "substantial compliance."

Initially, the federal government planned to use ECF standards for Medicaid SNFs, but this idea was dropped when it became evident that most homes could not qualify. The 1967 amendments to the Medicaid legislation authorized two categories of Medicaid nursing homes: SNFs and ICFs. Development of certification regulations for both categories proved to be very controversial. The Congress, prompted by consumer advocates and some professional groups, wanted stringent standards to protect the patients/residents. Some state governments and the nursing home industry were concerned about costs of stringent standards and the ability of many nursing homes to meet them.

The final Medicaid SNF regulations were issued in 1974 and the ICF regulations in 1976. There was substantial evidence made public throughout this period that very large numbers of nursing homes were not in compliance with federal standards and that most states were not enforcing them. In 1974, the Office of Nursing Home Affairs in the U.S. Department of Health, Education, and Welfare (HEW) began a study of the quality of care in nursing homes. The study found that "the extent to which nursing homes comply with the federal standards of care varies widely."[40] The study also found that the survey and certification regulations were concerned only with a facility's capacity to provide the required services, not with the quality of the services being provided. Substantial efforts were made to develop new, and to revise, strengthen, and clarify existing, standards in the late 1970's.

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In 1980 the HCFA published its proposed new regulations in the *Federal Register*. These would have, among other things,

1. combined the SNF and ICF regulations into a single set applicable to all nursing homes;
2. consolidated all resident care planning requirements into a single condition of participation requiring a resident care management system that called for interdisciplinary teams to assess residents and plan their care; and
3. elevated the residents' rights standard to a condition of participation.

Only one of the 1980 proposed changes was actually promulgated: the elevation of residents' rights from a standard to a condition. This was signed in January 1981 by the outgoing Secretary of the U.S. Department of Health and Human Services (HHS), but was promptly rescinded by the new Secretary. Thus, the regulations that were issued in the mid-1970s are still in place today despite widespread agreement that they are inadequate.

A recent legal development--the 1984 decision by the Tenth Circuit Court of Appeals in the *Smith v. Heckler* case[41]--requires the HCFA to modify the federal certification regulations so that they are more effective in assuring quality of care in nursing homes. This lawsuit (originally filed as *Smith v. O'Halloran*) was filed in 1975 on behalf of a group of nursing home residents in a Denver, Colorado, facility, alleging poor care, violation of residents' rights, and failures by government to monitor the nursing home. Plaintiffs sued the nursing home owners as well as the state health and Medicaid agencies and the Secretary of HEW. During the trial, residents proved a variety of violations of regulatory standards, including theft of personal funds, overuse of psychotropic drugs, inadequate care resulting in decubitus ulcers, inadequate skin and nail care, inadequate bowel assistance, and sanitation problems.

The case against the government agencies was based on the theory that the Medicaid statute requires a federal nursing home survey process that determines whether

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residents are receiving care they need, not merely whether facilities have the theoretical capacity to provide it. In 1978 the Colorado health and Medicaid agencies took the unprecedented step of agreeing with the nursing home plaintiffs and joining them in the case against HEW. The state's theory was that the federal survey system was both inadequate to determine whether residents received needed care and mandatory upon the state so that it could not develop a more appropriate system for Medicaid certification decisions.[42]

The case was nearly settled in 1980 when the HHS published proposed regulatory revisions that would have integrated a "patient care management system" into the survey system to evaluate actual resident care. But, these regulations were not promulgated, so the case was tried in 1982. The federal district court found that (1) serious deficiencies exist in some nursing homes, which it labeled "orphanages for the aged," (2) the current survey system is facility-oriented rather than resident-oriented, and (3) it is feasible for HHS to develop a survey system focusing on resident needs and care delivery. However, the court held that as a matter of law the Secretary of HHS had no duty to develop such a system under the Medicaid statute. The Federal Tenth Circuit Court of Appeals reversed the lower court's decision in 1984, holding that the Medicaid law does impose upon the Secretary a duty "to establish a system to adequately inform herself as to whether the facilities receiving federal money are satisfying the requirements of the Act, including providing high quality patient care."[41]

The appeals court returned the case to the district court to determine what survey system would satisfy the Secretary's duty. The HCFA has indicated to the court that it will implement a resident-oriented survey system by January 1, 1986.

The recommendations contained in this report follow from the committee's conclusion that profound changes are needed in the regulatory system to make it substantially more effective. The changes thus far proposed by the HCFA in response to the court decision do not address all of the significant problems that limit the effectiveness of the current regulatory system.

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Other Factors Affecting Quality of Care in Nursing Homes

Other Regulatory Policies

Three areas of regulatory policy other than certification regulations that may affect the quality of care provided by nursing homes are Medicaid payment policies, control of bed supply, and information reporting requirements. Despite the importance of these policy areas, the committee did not make recommendations on them for two reasons: (1) It was beyond the scope of its charge to address these issues seriously as part of its study effort, and (2) there is not enough clear evidence or other information now available to support specific recommendations for federal policy in these areas.

Nursing home care is paid for mainly from the private incomes or assets of the residents or their families and from Medicaid for those whose incomes and assets are low enough to qualify them for such support. There is almost no private health insurance coverage for long-term nursing home care. Half of the industry revenues, paying for part or all of the care of about two-thirds of the nursing home residents, comes from state Medicaid programs.[43] In most states Medicaid reimbursement rates are lower than the rates charged by the same nursing homes to private pay residents.[31] And because most states also have restricted the expansion of nursing home beds, the demand for beds exceeds the supply in all but a very few states. This supplier's market is advantageous to nursing home management because it allows nursing homes to be selective in their admissions and still keep their beds full. Administrators try to optimize (from their perspective) the mix of residents in their homes. In practice, this usually means they will favor admission of private-pay over public-pay residents, and--depending on the design of the state payment system--those who require less care over those who require a great deal. Demographic trends are likely to exacerbate the access problem, particularly for Medicaid and heavy-care residents, because the total number of people requiring long-term care is growing, and

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the proportion requiring a great deal of care also is growing.[44]

Each state establishes its own Medicaid eligibility rules, payment policies, and the amounts to be paid to nursing homes for allowable services to eligible residents. The federal law simply requires that the states' Medicaid payment rates be on a "reasonable cost-related basis," but an operational definition of this phrase has never been issued by the federal government. State payment methods and amounts vary widely. Although Medicaid payment policies contain powerful behavioral incentives for nursing home operators, not enough is now known about this complex question to make specific recommendations for federal policy.

Regulation of nursing home bed supply also is a state responsibility. Most states have maintained tight controls over the expansion of nursing home beds, despite strong evidence of excess demand, to constrain growth of their Medicaid budgets. The issue and the considerations affecting policy on controlling bed supply are discussed in Chapter 7.

Timely access to necessary data and other information is the life blood of effective regulation and of sound public policy development. But despite the importance of both federal and state government regulation in the nursing home industry, and the large proportion of public funds that flow into the nursing homes, there is a striking paucity of detailed information available about almost every aspect of nursing home operations. Information about the demographic characteristics of the residents, their medical, cognitive, and functional disabilities, from where they were admitted and, for those who are discharged, to where they are discharged, date back almost 10 years or are not available at all. Accurate, complete, and current information on the characteristics of nursing homes (their number, size, ownership, certification status, age) is not readily available.[45] Within state governments, the availability of information, and the way it is kept, varies widely.

Key financial information also is not available. What proportion of Medicaid-eligible residents contribute significantly to the cost of their care? How much? How

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does this vary by state? The federal government does not know. Very little is known about the effects of the "spend-down" requirement, the process by which private-pay nursing home residents "spend down" their assets to cover the cost of their care until they become eligible for Medicaid. How long does it take? What fraction of residents "spend down"? Data are fragmentary. Information on changing ownership patterns and on admission and discharge patterns are obtainable only from *ad hoc* studies conducted in limited areas for particular purposes. The last major survey (a sample survey) of nursing homes and residents was conducted by the National Center for Health Statistics in 1977. A new survey was started late in 1985, but the findings will not be available until late 1986 or 1987. Information on the outcomes of inspections and on enforcement actions also is incomplete and unreliable, both at the state and national levels.

By way of contrast, vast amounts of relatively current data and information are available about short-term hospitals, their patients, and finances. If more effective regulation and more rational public policy are to be developed in the long-term care area, serious efforts will have to be made to obtain the necessary data. The committee is firmly convinced that the federal government, particularly the cognizant committees of the Congress and the Department of Health and Human Services, should give this matter priority attention.

Consumers, the Community, and Nursing Home Management and Staff

Three other sets of factors affect quality of care and quality of life in nursing homes: (1) consumer involvement and consumer advocacy, (2) community interest and involvement in nursing homes, and (3) the motivation, attitudes and qualifications of nursing home management and staff. (All three are discussed in Chapter 6.)

Active participation by the residents in some aspects of management policy and care decisions can have important effects on quality of care and quality of life. Many

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important facility policy decisions rest on value judgments--they are not based entirely, or even primarily, on technical or managerial imperatives. Because resident quality of life is affected by such decisions, resident participation and preferences should be sought. Although the regulatory system can facilitate resident participation in decision-making, ultimately it depends on the residents themselves, their families, consumer advocates, and, most important, on the attitudes of the management and staff of the facilities.

Consumer advocacy plays an important role in quality assurance. Consumer advocates are essential because residents are a particularly vulnerable group and nursing home regulators are only occasional visitors to nursing homes. Advocates handle complaints and help individual residents in a variety of other ways. They represent residents as a group to management and government agencies. The Long-Term Care Ombudsman Program, authorized in the Older Americans Act in 1978, provides a statutory basis for the role of consumer advocacy. Unfortunately, the ombudsman program, as presently constituted and financed, is much less effective than it should--and could--be. Recommendations to strengthen it are contained in Chapter 6.

Outside visitors from the community in which the nursing home is set have an important positive effect on the quality of life of residents and on the quality of performance of the staff. It is thus very important to stimulate and facilitate community involvement in nursing homes.

Positive motivation and attitudes on the part of the owners and managers of nursing homes, and well-trained, well-supervised, and properly motivated staff are essential for high-quality care. Although pressures by regulators and consumers can have important positive effects on staff and management attitudes and behavior, they are not sufficient to produce the motivation and attitudes that will attract the kinds and quality of personnel needed to provide high quality of care and quality of life to nursing home residents. Such attitudes must be nurtured by sources within the industry and the educational and professional institutions associated with

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it. The regulatory system can encourage this process by recognizing and rewarding outstanding performance.

CONCLUSIONS

This report contains the following major conclusions derived in part from the prior experience and knowledge of the committee members and in part from the findings of this study.

1. *Quality of care and quality of life in many nursing homes are not satisfactory.* Despite extensive government regulation for more than 10 years, some nursing homes can be found in every state that provide seriously inadequate quality of care and quality of life. At the same time, examples of good and even excellent care can be found in other nursing homes in the same states. Because most nursing home residents live in nursing homes for many months or years, quality of life is as important as quality of care in these institutions. It is possible to define and assess quality of care and at least some aspects of quality of life. Furthermore, it is possible to develop and employ techniques for quality assurance that incorporate reasonably objective measures to judge the quality of care being provided by a facility. The concepts of quality, quality assessment, and quality assurance are discussed in Chapter 2, and specific recommendations to strengthen the quality assurance effectiveness of the survey and certification regulations are discussed in Chapters 3, 4, and 5.

2. *More effective government regulation can substantially improve quality in nursing homes. A stronger federal role is essential.* Regulation of nursing homes both by state and federal governments is necessary to assure safety and acceptable quality of care for nursing home residents because of the vulnerability of the residents and the lack of institutional choices available to them. The committee is convinced that more effective government regulation can achieve substantial improvement in quality of care in many nursing homes in all states. A stronger federal leadership role is essential for

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improving nursing home regulation because not all state governments have been willing to regulate nursing homes adequately unless required to do so by the federal government. Chapters 3, 4, and 5 discuss these issues at length.

3. *Specific improvements are needed in the regulatory system.* A major reorientation of the regulatory system is needed to make it focus on the care being provided to residents and the effects of the care on their well-being. This will require revision of most aspects of the regulatory system, including the nursing home performance criteria and standards (the "conditions of participation" and "standards"), the surveillance (survey) process, compliance (enforcement) policies and procedures, and the systems for collecting and analyzing the data and other information needed for effective regulation. Chapter 3 discusses the problems with the current criteria and recommends some major changes. Chapter 4 discusses the problems with the survey process and recommends changes to strengthen it. Chapter 5 discusses enforcement problems and recommends ways to strengthen and improve the enforcement of performance standards.

4. *There are opportunities to improve quality of care in nursing homes that are independent of changes in the Medicaid payment policies or bed supply.* It is especially important to reorient and strengthen nursing homes to reduce or eliminate the many remediable weaknesses in the process of monitoring nursing home performance, and to strengthen compliance (enforcement) policies and procedures. Immediate steps to remedy current inadequacies in these three interrelated aspects of the regulatory system should be undertaken immediately. The committee recognizes that Medicaid payment policies clearly influence management decisions on admission and retention of residents; on the numbers, types, qualifications, and training of staff; and on the amount and quality of food, supplies, equipment and other resources to be purchased. All of these decisions affect quality of care. Unfortunately, the evidence of the effects on nursing home operations--and especially on quality of care--of different state approaches to Medicaid reimbursement policy is still not conclusive enough, nor

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is there sufficient professional consensus, to enable the committee to recommend adoption of a specific approach. For various reasons--including lack of precision in quality assessment--the complex relationships between costs, charges, reimbursement methods and amounts, and quality are not yet clear. There obviously must be a minimum reimbursement amount below which it is not possible to provide adequate care. But available evidence has not shown what that amount is. Since this is an issue of major importance, the HCFA should continue to support research and demonstration projects on the effects of Medicaid reimbursement policy on quality of care and quality of life in nursing homes. In this connection, one of the major recommendations discussed in Chapter 3--resident assessment--will make it feasible to arrive at objective methods of assessing quality of care that will be important for such studies. The issues are discussed more fully in Chapter 7.

Similarly, bed supply policy is a difficult issue. Although there clearly is excess demand for nursing home beds in most states, there also is evidence that some nursing home residents could be better cared for in alternative long-term-care settings if such were available. The main policy argument for constraining nursing home bed supply is that increasing bed supply would inhibit the development of more appropriate alternative long-term-care facilities and programs. But constraining the bed supply does not appear to have accelerated development of such programs because their development is probably tied closely to changes in payment policy. With only a few exceptions, the states control nursing home bed supply very tightly for a short-term political reason: to constrain growth of their Medicaid budgets. There is no federal policy either on bed supply or to facilitate development of alternatives to nursing home care. Some members of the committee favor policies that would encourage states to ease bed shortages. But the committee as a whole does not believe there is sufficient evidence or sufficient professional consensus to recommend either to the federal government or to the states a specific policy until the much larger

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issue of more appropriate financing of long-term-care services has been addressed.

5. *Regulation is necessary but not sufficient for high-quality care.* Skilled and properly motivated management, well-trained, well-supervised, and highly motivated staff, community involvement and support, and effective consumer involvement all are required. Although most of these factors are affected by regulation, they also contain important areas that are not. These issues are discussed, and recommendations are made, in Chapter 6.

6. *A system to obtain standardized data on residents is essential.* To reorient the regulatory system from its current "structural" and "facility-centered" orientation to a "resident-centered" and "outcome-oriented" approach will require development and introduction of a standard resident assessment data system that has multiple uses both for nursing home management and for government regulatory agencies. This concept is discussed in Chapters 2, 3, and 7.

7. *The regulatory system should be dynamic and evolutionary in outlook.* Specific regulatory standards should be modified to reflect changes in the art of long-term care, in experience with the regulatory system, and in the techniques of assessing outcomes more objectively.

The recommendations contained in this report collectively require many changes in all aspects of the regulatory system. These recommended changes should not be viewed as definitive and final. The effectiveness of the recommended modifications in the regulatory system should be followed closely. Experience is likely to expose the need for further changes. An effective regulatory system cannot be a static structure; it has to be conceived as being dynamic and evolutionary. The regulations will have to be modified periodically to keep pace as new knowledge becomes available about the changes in the domains of concern--the capabilities and performance of the facilities, the characteristics of the residents, and the knowledge of the effects of various care processes, techniques, and arrangements on the

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quality of care and quality of life of nursing home residents.

SUMMARY OF RECOMMENDATIONS

The committee's recommendations are contained in Chapters 3-7. They deal primarily with regulatory criteria, with the process of inspecting and certifying nursing homes, with the enforcement process, with the ombudsman program, and with issues requiring further study.

Regulatory Criteria

The following changes in the federal certification criteria are recommended:

1. The regulatory distinctions between SNFs and ICFs should be eliminated.

Recommendation 3-1: The regulatory distinction between SNFs and ICFs should be abolished. A single set of conditions of participation and standards should be used to certify all nursing homes. The current SNF conditions and standards, with the modifications and additions recommended below, should become the bases for new certifying criteria.

The reasons for making this recommendation are set forth in Chapter 3.

2. A new condition of participation on resident assessment is required. This is of fundamental importance because it has broad implications for both regulation and management (see Chapter 3, Resident Assessment).

Recommendation 3-2: A new condition of participation on resident assessment should be added. It should require that in every certified facility a registered nurse who has received appropriate training for the purpose shall be

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responsible for seeing that accurate assessments of each resident are done upon admission, periodically, and whenever there is a change in resident status. The results should be recorded and retained in a standard format in the resident's medical record.

2. The existing SNF conditions of participation and standards should be rewritten in accordance with the following principles:

- Whenever appropriate, the criteria should address residents' needs and the effects of care on residents, and on the performance of a facility in providing care rather than on its capability to perform.
- The criteria should be based on the best professional standards for providing high quality of care and quality of life to nursing home residents.
- The criteria should be drafted clearly and with as much specificity as possible so that they can be understood by facilities, applied consistently by surveyors, and be legally enforceable.
- The criteria should be internally consistent, logical, and comprehensive.
- The criteria should include physical, mental, and social functioning; nursing care; nutritional status; social services; physician care; psychological care; pharmacy; dental care; environment; residents' rights; emotional well-being; personal choice; satisfaction; and community interaction.
- The criteria should be sensitive to each facility's case mix--that is, the variations in the services required and outcome expectations for residents with different needs found in one facility.
- The criteria should not be unnecessarily burdensome on facilities.

Recommendation 3-3: The existing SNF conditions and standards should be rewritten in accordance with the above principles and made applicable to all nursing homes.

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4. Because quality of life, in addition to quality of care, is particularly important in nursing homes, the committee believes that it should be incorporated as a condition of participation.

Recommendation 3-4: A new condition of participation concerning quality of life should be added to the certification regulations. The condition should state that residents shall be cared for in such a manner and in such an environment as will promote maintenance or enhancement of their quality of life without abridging the safety and rights of other residents.

5. There is a need to reorient the approach to regulation of nursing homes to make it more resident-centered and outcome-oriented. This requires a new condition of participation on quality of care.

Recommendation 3-5: A new condition of participation on quality of care should be added to the certification regulations. It should state that each resident is to receive high-quality care to meet individual physical, mental, and psychosocial needs. The care should be designed to maintain or improve the residents' physical, mental, and emotional well-being.

6. Residents' rights should be raised from a standard to a condition of participation and some new residents' rights standards should be added.

Recommendation 3-6: The existing standard on residents' rights should be made into a condition of participation. The condition should state that every resident has certain civil and personal legal rights that must be honored by the staff of the facility. Rights specified in this condition, as they pertain to a resident who has been adjudicated incompetent in accordance with state law, shall devolve to the resident's guardian, or, if required by the state, a responsible party. In cases where the attending physician determines that a legally competent resident is incapable of exercising a right, the

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conditions and circumstances shall be fully documented in the medical record and the right shall devolve to a responsible party. The following standards should be added to the residents' rights condition:

a. All residents admitted to the facility shall be told that there are legal rights for their protection during their stay at the facility and that these are described in an accompanying written statement. Reasonable arrangements shall be made for those who speak a language other than English. At such time as the rights set forth in this condition are revised, residents shall be given the updated information. Further explanation of the written statement of rights shall be available to residents and their visitors upon reasonable request to the administrator or other designated staff person.

b. Each resident has the right to know the name, address, and phone number of the state survey office, state or local nursing home ombudsman office, and state or local legal service office. The facility shall post such information in a location accessible to residents and visitors.

c. Each resident has a right to see written facility policies. Facilities shall make policies available on request. Facilities shall post state survey reports and plans of correction in a location accessible to residents.

d. Each resident may inspect his/her medical and social records upon request to the facility. The resident may request and receive copies of the records at a photocopying cost not exceeding the amount customarily charged in the facility's community for similar services. (This overrides state law and/or regulations if they are in conflict.)

e. Each resident must receive prior notice of transfer, discharge, and lapse of bed-hold periods. The facility must notify the resident, resident's representative, and attending physician in writing

(1) at least 3 days prior to the lapse of bed-hold periods,

(2) at least 3 days prior to intrafacility transfer.

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(3) at least 4 days prior to discharge from the facility except as specified in documented emergencies.

The notice must contain the reason for the proposed transfer, the effective date, the location to which the facility proposes to transfer the resident, a statement that the resident may contest the proposed action, and the address and telephone number of the state or local nursing home ombudsman.

f. Each resident, along with his/her family has the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated responsible for providing this assistance and for responding to written requests that result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies.

g. Each resident has the right to meet with visitors and participate in social, religious, and political activities at their discretion so long as the activities do not infringe on the rights of other residents. This includes the right to join others within and outside the facility to work for improvement in long-term care. The facility must permit each resident to receive visitors and associate freely inside or outside of the facility with persons and groups on the resident's own initiative. Visitors must be granted access to residents. The residents, however, have the right to refuse or terminate any visit.

7. Seven of the current conditions of participation--governing body and management, utilization review, transfer agreement, disaster preparedness, medical direction, laboratory and radiological services, and medical records--should be consolidated into one new condition to be called "administration." New standards should be added on nurse's aide training, access, Medicaid discrimination, notification, and consumer participation.

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Recommendation 3-7: A new condition of participation entitled "Administration" should be established. The following current conditions of participation should be reclassified as standards under this new condition: governing body and management, utilization review, transfer agreements, disaster preparedness, medical direction, laboratory and radiological services, and medical records.

Recommendation 3-7A: The current requirements for institutional planning and submission of quarterly staffing reports should be eliminated in drafting the new administration condition.

Recommendation 3-7B: A new standard, nurse's aide training, should be added to the administration condition. The standard should require that all nurse's aides complete a preservice state-approved training program in a state-accredited institution such as a community college.

Recommendation 3-7C: A new standard should be written under the administration condition that prohibits facilities that have signed a Medicaid Provider Agreement from having different standards of admission, transfer, discharge, and service for individuals on the basis of sources of payment.

Recommendation 3-7D: When the governing body and management condition is rewritten and incorporated in the new administration condition, the current standard "j" should be changed to require the facility to record at admission and periodically confirm or update the identity of a guardian, conservator, or resident's representative to be notified in the event of (1) care conferences; (2) changes in the resident's physical, mental, or emotional status; (3) an accident involving the resident; (4) change in billing; (5) change of room; (6) discharge from the facility; or (7) changes in federal or state residents' rights. Notification should be timely.

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Recommendation 3-7E: A new standard should be added to the administration condition that would require every facility to develop and implement a plan for regular resident participation in decision-making in the facility's operations and policies and for presentation of resident concerns. Forms of resident participation can include, but are not limited to, resident councils, regularly scheduled resident forums, resident issue or program committees, and grievance committees. Facilities should include existing resident councils and/or other resident representatives in developing this plan.

Recommendation 3-7F: Two new elements should be added to the governing body and management standard as follows:

a. Certified nursing homes should be required to permit access to the homes by an ombudsman (whether volunteer or paid) who has been certified by the state. With permission of a resident or legal guardian, a certified ombudsman should be allowed to examine the resident's records maintained by the nursing home.

b. Any authorized employee or agent of a public agency, or any authorized representative of a community legal services organization, or any authorized member of a nonprofit community support agency that provides health or social services to nursing home residents should be permitted access at reasonable hours to any individual resident of any nursing home.

8. Standards in the social services and physical environment conditions should be strengthened.

Recommendation 3-8: Standard 5, "Other Environmental Considerations" in the Physical Environment Condition currently reads " . . provision is made for adequate and comfortable lighting levels in all areas, limitation of sounds at comfort levels, maintaining a comfortable room temperature . . . ." It should be amended to add, at this point, "that is within acceptable ranges of operative temperature and humidity for persons clothed in typical summer or winter clothing at light, mainly sedentary activities, as specified in the ANSI-ASHRAE Standard

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55-1981." This is the standard prescribed by the nationally recognized American National Standards Institute. Waivers may be granted for existing facilities until such time as substantial renovation takes place.

Recommendation 3-9: The present social service condition should be changed to require that each facility with 100 beds or more be required to employ at least one full-time social worker. Qualifications for this position should be a bachelor's degree in social work, a master's degree in social work, or some equivalent degree in an applied human service field at the bachelor's level or higher as approved by the state. Facilities with fewer than 100 beds or those in rural areas that have made a good-faith effort and have been unable to recruit a qualified social worker with the required credentials may substitute a contractual arrangement with a community agency or with an independent social work consultant. However, the HCFA should establish a minimum level of effort for social services in exempted facilities--for example, one day of consultation per week.

Monitoring Nursing Home Performance

The following recommendations are made to strengthen the process of determining the extent to which nursing homes are complying with the conditions of participation:

1. Medicare and Medicaid survey and certification requirements should be consolidated.

Recommendation 4-1: Medicare and Medicaid survey and certification process requirements should be consolidated in one place in the Code of Federal Regulations to promote consistency.

2. The timing of surveys should be adjusted to make them less predictable.

Recommendation 4-2: The timing of surveys should maximize the element of surprise; the standard annual survey should

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be conducted somewhere between 9 and 15 months after the previous annual survey, with the average across all facilities within each state remaining at 12 months. Additional standard surveys also should take place whenever there are key events, such as a change in ownership. Independent of the survey cycle, all facilities should be required to pass rigorous life safety code and food inspections at regular intervals.

3. The following two survey instruments and protocols based on the new conditions and standards should be developed:

a. a standard, relatively short survey, that would be resident-centered and use key outcome indicators to determine quality of care, and

b. an extended survey that would entail a comprehensive examination of the nursing home's operations. The extended survey would be used if the standard survey findings indicated that there were--or might be--evidence of inadequacies in the quality of care being provided to some or all of the residents. Good nursing homes would normally experience only the standard survey.

Recommendation 4-3: Two new survey protocols should be designed and tested to implement the new conditions and standards recommended in Chapter 3: a standard survey and an extended survey. Both must be based on the revised conditions of participation and standards.

4. The standard survey process would entail an audit of the resident assessment data maintained by the facility and would rely on a case-mix-referenced sample of residents to gather the information required by the standard survey instrument.

The extended survey would enlarge the sample of residents examined and increase the comprehensiveness of the standard protocol to look at compliance with all elements of all standards. It would further document poor resident outcomes and explore the extent to which structural and process factors may have contributed to these outcomes.

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Recommendation 4-4: Both standard and extended surveys should assess samples of residents stratified by standard case-mix categories. Case-mix definitions, and the procedures and sample sizes required to attain a prespecified level of precision, should be established by the HCFA.

Recommendation 4-5: The standard survey should rely on "key indicators" of quality of resident life and care that would be prescribed by the HCFA. These key indicators would measure poor resident outcomes and other resident and facility conditions that might be caused by noncompliance with the federal conditions and standards and should be investigated further by the survey agency.

Recommendation 4-6: Facilities that perform poorly on key indicators of quality of resident care or life should be subjected to a full or partial extended survey, depending on the range of problem areas discovered. The purpose of the extended survey is to determine the extent to which the facility is responsible for the poor outcomes due to noncompliance with the federal conditions and standards.

Recommendation 4-7: Quality assessment in the survey process should rely heavily on interviews with, and observation of, residents and staff, and only secondarily on "paper compliance," such as chart reviews, official policies and procedures manuals, and other indirect measures of actual care given and resident outcomes.

5. The survey process should be coordinated with the complaint-handling process, and the latter would be strengthened.

Recommendation 4-8: The HCFA should require states to have a specific procedure and sufficient staff to properly investigate complaints.

6. The survey process should formally seek information directly from consumers (residents and their advocates).

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Recommendation 4-9: The HCFA should incorporate in its survey operations manual the following additional procedures to be followed by surveyors in addition to interviews with those residents sampled for the survey protocols:

- *At the beginning of the survey, surveyors should meet briefly with members of the facility's resident council or with a group of willing and capable residents to elicit general information about services and resident satisfaction as well as to identify any areas of particular concern.*
- *Resident representatives should participate in the part of the exit conference where deficiencies are cited and the plan of correction is discussed.*
- *At the close of the survey, the following notice should be posted in a location accessible to residents and visitors:*

> *The (state survey agency) completed its regular certification survey of (facility name) on (date). Anyone wishing to provide additional information may contact the (state survey agency) before (date).*
> *(address)*
> *(phone)*

7. Positive incentives for good performance should be incorporated into the survey and certification process.

Recommendation 4-10: In addition to exempting good facilities from extended surveys, ways should be explored to commend superior performance.

8. The HCFA should require the state agencies to implement a program to develop and support consistent and reliable surveys.

Recommendation 4-11: The new survey protocols, including the forms, procedures, and guidelines used by surveyors, should be designed in accordance with the revised and

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amended conditions and standards recommended in Chapter 3, and they should be revised as the conditions and standards are changed in the future.

Recommendation 4-12: All survey protocols (instruments and procedures) should be tested so that they are capable of yielding reliable and consistent results when used by properly trained surveyors anywhere.

Recommendation 4-13: A sample of facilities should be subject to an extended survey each year. Information from this sample should be used to validate and improve the standard survey.

Recommendation 4-14: The HCFA should require the state agencies to implement a program to develop and support consistent and reliable surveys. This program should be based on effective training and monitoring of surveyor performance to reduce inconsistency.

9. Several steps should be taken to strengthen the regulatory capacity of the states:

- Full federal funding should be provided for state survey and certification activities.
- State surveyor qualifications should be strengthened.
- Both federal and state surveyor training efforts should be increased.
- The results of research and evaluation studies should be analyzed and disseminated by the HCFA.

Recommendation 4-15: Title XIX of the Social Security Act should be amended to authorize 100 percent federal funding of costs of the nursing home survey and certification activities of the states. This authority should be extended for 3 years, after which time a federal-state matching ratio should be reestablished. The HCFA should develop a standard formula for distributing funds to the states under this authority so that each state is funded on an equal basis in proportion to its federal certification workload.

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Recommendation 4-16: The HCFA should revise its guidelines to make them more specific about the qualifications of surveyors and the composition and numbers of survey team staff necessary to conduct adequate resident-centered, outcome-oriented inspections of nursing homes. As a minimum, every survey team should include at least one nurse. For use on extended surveys, the survey agency should have specialists on staff (or, in small states, as consultants) in the disciplinary areas covered by the conditions and standards (for example, pharmacy, nutrition, social services, and activities).

Recommendation 4-17: Federal training efforts and support of state-level training programs should be increased, especially during the period of transition to the new survey process, and during the implementation of the new resident assessment condition of participation.

Recommendation 4-18: National data about survey operations and results, and from any experiments and demonstrations sponsored by the HCFA or the states, should be collected, analyzed, and disseminated by the federal government to facilitate continued improvement in survey methods.

10. Federal oversight capabilities vis-a-vis state survey operations should be strengthened and the HCFA should be given authority to withhold a portion of Medicaid matching funds from states that perform the survey and certification function inadequately.

Recommendation 4-19: The HCFA should increase its capabilities to oversee state survey and certification of nursing homes and to enforce federal requirements on states as well as facilities by

- *adding enough additional federal surveyors to each regional office to ensure that the random sample of nursing homes surveyed each year in each state is large enough to allow reasonable inferences about the adequacy of the state's survey and certification activities;*

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- *scheduling "look-behind" surveys so that valid comparisons can be made of the findings of federal and state surveys; and*
- *amending Title XIX of the Social Security Act to authorize the HCFA to withhold a portion of Medicaid matching funds from states that perform inadequately in their survey and certification of nursing homes.*

11. Inspection of care should be integrated with the certification survey.

Recommendation 4-20: The inspection-of-care function should be carried out as part of the new resident-centered, outcome-oriented survey process. But individual resident reviews should be required for a sample of residents (private-pay as well as Medicaid) rather than for all residents (although individual states may elect to continue 100 percent reviews).

12. A realignment of federal and state certification role relationships vis-a-vis Medicare and state-owned facilities is necessary.

Recommendation 4-21: The respective roles and responsibilities of the federal and state governments should be realigned as follows:

- *The states should be responsible for certifying all Medicare and Medicaid facilities (except state institutions) according to federal requirements.*
- *The HCFA should monitor state performance more actively and be responsible for conducting surveys of, and certifying, state-owned institutions directly.*

Enforcing Compliance with Federal Standards

The following improvements in enforcement are recommended:

1. The HCFA should revise its guidelines for the post-survey enforcement process.

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Recommendation 5-1: The HCFA should revise its guidelines for the post-survey process. Revisions should include

- *specifying that survey agency personnel not be used as consultants to providers with compliance problems;*
- *specifying how to evaluate plans of correction and what constitutes an acceptable plan of correction;*
- *specifying the circumstances under which onsite followup visits may be waived;*
- *specifying circumstances under which formal enforcement action should be initiated, and how actions should be taken; and*
- *requiring that states have formal enforcement procedures and mechanisms.*

2. The Medicaid authority should be amended to authorize a set of intermediate sanctions for use by the states and the federal government.

Recommendation 5-2: The Medicaid authority should be amended to authorize a specified set of intermediate sanctions for use by states and by the federal government in enforcing compliance with nursing home conditions of participation and standards. The HCFA should then develop and issue detailed regulations and guidelines to be followed by the states and by the HCFA in using these sanctions. The sanctions should include

- *ban on admissions,*
- *civil fines,*
- *receivership,*
- *emergency authority to close facilities and transfer residents.*

3. The Medicaid statute should be amended to authorize sanctions for use against chronic or repeat violators of certification regulations.

Recommendation 5-3: The Medicaid statute should be amended to provide authority to impose sanctions on chronic or repeat violators of certification regulations.

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The HCFA should develop detailed procedures to be followed by the states to deal with such facilities. Procedures should include, but not be limited to,

- *the authority to impose more severe sanctions,*
- *a requirement to consider a provider's previous record before certifying or recertifying, and*
- *the responsibility to obtain satisfactory assurances prior to recertifying, that the deficiencies that led to a termination will not recur.*

4. The Medicaid statute should be amended to strengthen the effectiveness of sanctions.

Recommendation 5-4: The Medicaid statute should be amended to make the appeals process on sanctions, particularly decertification, less permissive. The HCFA should issue regulations and guidelines to implement this new authority.

5. The HCFA should strengthen state enforcement capabilities.

Recommendation 5-5: The HCFA should strengthen state enforcement capabilities by

- *requiring states to commit adequate resources to enforcement activities, including legal and other enforcement-related staff;*
- *requiring survey and certification survey agency staffs to include enforcement-related specialists, such as lawyers, auditors, and investigators, to work as part of special survey teams for problem situations and to help support enforcement decision-making;*
- *including more training in investigatory techniques, witness preparation, and the legal system in the basic surveyor training course; and*
- *providing federal training support for state survey agency and welfare agency attorneys in nursing home enforcement matters.*

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Other Factors Affecting Quality of Care and Quality of Life in Nursing Homes

The following means to enhance the effectiveness of consumers and consumer advocates in quality assurance are recommended:

1. The HCFA should require states to make public all nursing home inspection and cost reports.

Recommendation 6-1: The HCFA should require states to make public all nursing home inspection and cost reports. These documents should be required to be readily accessible at nominal cost to consumers and consumer advocates, including state and local ombudsmen.

2. The ombudsman program should be strengthened by amending the Older Americans Act.

Recommendation 6-2: The Older Americans Act should be amended to:

- *establish the ombudsman program under a separate title in the Act;*
- *increase funds for state programs by authorizing federal-state matching formula grants for state ombudsman programs. The formula should provide each state with a minimum annual budget in the range of $100,000 (1985 dollars) plus an additional amount based on the number of elderly residents in the state. The federal-state matching ratio should be two-thirds federal to one-third state funds.* (Although the committee did not study in any depth the budget requirement, this minimum amount is intended to provide the ombudsman program with, for example, the capability to support, at a minimum, a full-time professional and secretary and sufficient travel and training funds to recruit, train, and certify volunteers as local ombudsmen.)
- *establish a statutory National Advisory Council composed of state ombudsmen, state and local aging agencies, provider and consumer representatives, state regulators, health care professionals (physicians, nurses,*

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administrators, social workers), and members of the general public to advise on administration, training, program priorities, development, research, and evaluation;

- *authorize state-certified substate and local ombudsmen, including trained, unpaid volunteers, access to nursing homes and, with the permission of the resident, to a resident's medical and social records;*
- *authorize public legal representation for ombudsman programs;*
- *exempt the ombudsman programs, including substate ombudsmen who are supported by funds from the state ombudsman program, from the antilobbying provisions of OMB Circular A-122.*

3. The Secretary of HHS should direct the Administration on Aging (AoA) to take steps to provide effective national leadership for the Ombudsman Program.

Recommendation 6-3: The Secretary of HHS should direct the Administration on Aging (AoA) to take steps to provide effective national leadership for the Ombudsman Program. At a minimum the Commissioner of AoA should designate a senior full-time professional and some supporting staff to assume responsibility for administering the program. Priority should be given to establishing a national resource center for the program that would develop, in consultation with state programs, an information clearinghouse, training and other materials to assist states, and guidance to states on data collection and analysis. The center should advise on establishing program priorities, and sponsor research and evaluation studies.

4. The HCFA should require state long-term care regulatory agencies to develop written agreements with state ombudsman programs covering information-sharing, training, and case referral.

Recommendation 6-4: The HCFA should require state long-term-care regulatory agencies to develop written agreements with state ombudsman programs covering information-sharing, training, and case referral.

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Issues Requiring Further Study

Information Systems

HHS should undertake a study to design a system for acquiring and using resident assessment data. A study also should be initiated to determine what other data about nursing homes are needed for regulatory, policy development, and other public purposes.

Recommendation 7-1: The Secretary of HHS should order a study to design a system for acquiring and using resident assessment data to meet the legitimate and continuing needs of state and federal government agencies. The Secretary also should order a study to determine the needs for other data about nursing homes that would facilitate regulation and policy development. This study should recommend specific ways to collect, analyze, and publish or otherwise make such data publicly available.

Medicaid Payment Policies

Further study is needed to determine optimal Medicaid payment policies.

Nursing Home Bed Supply

The policy on controlling the supply of nursing home beds is related to the issue of developing a broader array of interrelated long-term-care services. This, in turn hinges on the development of more appropriate private and public financing arrangements and policies. The federal government should undertake a systematic study of these interrelated issues to facilitate development of appropriate policies in these areas.

If the committee's major recommendations are carried out there may be some effect on the number of currently certified nursing homes that will continue to participate in the Medicaid program. It is likely that poorly managed marginal or substandard facilities will be forced either

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to improve their performance or go out of business. Most of those that go out of business are likely to be sold to other owners that will install more competent management and staff and continue in operation. It is possible, however, that some facilities may elect to withdraw from participation in the Medicaid program. There is no way of determining beforehand to what extent, if any, this is likely to occur. Or, if it does occur to a significant extent, whether states will respond by easing their restrictions on expansion of bed supply only for certified homes, or by making licensure contingent on participation in the Medicaid program.

Staffing of Nursing Homes

Based on the availability of systematic resident assessment data, two kinds of staffing studies should be undertaken: (1) studies to develop a minimum staffing algorithm relating staffing to case mix, and (2) studies on staff qualifications.

Single- Versus Multiple-Occupancy Rooms

The HCFA should commission a study of the costs and benefits of single-occupancy rooms compared to multiple-occupancy rooms in nursing homes.

Recommendation 7-2: The HCFA should commission a study of the costs and benefits of single-occupancy rooms compared to multiple-occupancy rooms in nursing homes. The study should be designed to obtain data about the effects of single rooms on the quality of life of various types of nursing home residents. It should be completed within 2 years after it has been authorized. It should contain recommendations for the desired proportions of single- and multiple-occupancy rooms in nursing homes. It also should recommend required proportions in future new construction and major remodeling of existing buildings.

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